BS 385/147
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DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Better Services for the Mentally Ill

Presented to Parliament by the Secretary of State for Social Services
by Command of Her Majesty
October 1975

LONDON
HER MAJESTY'S STATIONERY OFFICE
£1·35 net

Cmnd 6233

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FOREWORD

1. Mental illness is a major health problem, perhaps the major health problem of our time. It is also a major social problem. At least 24 million working days are lost in England each year by people suffering from mental ill-health. Some 5 million people* each year consult their general practitioners about a mental health problem. Others seek the help of the social services because a pressing consequence of their psychological disturbance is a social, housing, or domestic crisis. By far the great majority of these people are never referred beyond primary care to the specialist psychiatric services. Many others survive spells of stress and emotional ill-health without any professional help.

2. But though only a small proportion of diagnosed mental illness is referred to the specialist psychiatric services, this proportion represents some 600,000* people each year.

3. It is wrong to think of these 600,000 more seriously ill people as being simply a mental hospital problem. Indeed, there has for years been general recognition of the significance of the social and environmental aspects of mental illness. Yet although it is sixteen years since the Mental Health Act of 1959 gave legislative recognition to the importance of community care, supportive facilities in a non-medical, non-hospital setting are still a comparative rarity. In 1973/4 nearly £300 million† was spent on hospital services for the mentally ill; by comparison just over £15 million† was spent on personal social services, of which some £6·5 million† was on day and residential facilities. In March 1974 31 local authorities, as then constituted, had no residential accommodation for the mentally ill and 63 no day facilities.

4. Specialist care is still mainly based in large, geographically isolated mental hospitals, nearly all dating from the last century and designed for custodial care. Their outward appearance is often forbidding. Staffing levels are often less than adequate. The equivalent of 835 full time consultant psychiatrists share clinical responsibility for about 250,000 adult in-patients each year, over 1½ million out-patient attendances, and more than 2 million day patient attendances. Their numbers are, moreover, unevenly distributed through the country. Nurses and other professional staff often have similarly daunting responsibilities. Basic facilities and amenities are often lacking. At the last count in 1974 more than 24,000 patients did not have full personal clothing of their own; many did not have a cupboard in which to hang their clothes. A number of large hospitals were still below the minimum standard for domestic staffing set by my Department for achievement by March 1973.

5. There have of course been some improvements and changes. The Hospital Advisory Service in their Annual Reports for 1973 and 1974 have recorded a continuing improvement in hospital services generally. Out-patient and day patient services have expanded and the number of in-patients has fallen.

6. But these improvements are not getting at the core of the problem. What we have to do is to get to grips with shifting the emphasis to community care. The problems are many. Social services facilities—hostels, day centres,

*England only.
†Revenue expenditure (November 1974 prices).

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group homes—have to be built up from their present minimal levels. Staff to run them have to be recruited and trained, and the implications for trained and experienced social work staff have to be recognised and provided for. Psychiatric services have to be developed locally, in general and community hospitals and in health centres. The balance of resources between health and the personal social services has to be shifted.

7. We have to recognise, moreover, that the pace at which community based care can be introduced depends not only on resources but on the pace of response of the community itself. That means nearly every one of us, for the likelihood is that each of us has a friend, relative or neighbour with a mental health problem. There is much scope for greater public understanding of the nature of mental illness—in particular for people to appreciate the extent to which modern methods of treatment can succeed in controlling the kind of disturbed behaviour which was associated with admission to a mental hospital 20 or more years ago. But this is only one side of the problem. In recent years community care has been urged—not only for the mentally ill—but for a growing number of different groups of ill or disabled people. All with good reason. But the demands which these make in total upon the community must not be greater than the community can accept.

8. Even in favourable economic circumstances it would obviously take a long term programme to achieve in all parts of the country the kind of change we are advocating. Moreover in a time scale of this dimension advances in knowledge are themselves bound to lead to changes in ideas about the desirable pattern of services. In present economic circumstances there is clearly little or no scope for substantial additional expenditure on health and personal social services, at least for the next few years. What then are we to do? Local services mean more day hospital treatment, more day care, more treatment and support in the home itself; and less in-patient treatment. Indeed the savings on expensive in-patient treatment should mean, taking health and social services together, little increase in total running costs. But the savings and the expenditure are not always simultaneous, and the net effect, overall, on running costs does not give a complete picture of the implications for different sectors of the health and personal social services. The policy can *only* be achieved if there is substantial capital investment in new facilities and if there is a significant shift in the balance of services between health and local authority. In the present state of financial stringency we have therefore felt bound to ask ourselves whether we should issue the White Paper at all.

9. It is clear that the scope for making progress during the next few years will be very limited. Without increased community resources the numbers in mental hospitals cannot be expected to fall at the rate they might otherwise have done. Delay in building up local services must mean too that it is unlikely that we shall be able to see in every part of the country the kind of service we would ideally like within even a twenty-five year planning horizon. But equally we must face the fact that any programme for the improvement and development of so large a sector of the health and social services involves substantial investment and a long-term programme. We believe, moreover, that in a period of severe financial restraint it is even more important that there should be a clear statement of policy objectives against which priorities can be assessed.

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10. We have therefore decided to proceed with publication of the White Paper, but on the basis that it is a long-term strategic document indicating the general direction in which we should move and the general background against which we should be taking decisions. I cannot over-emphasise that this White Paper must not be regarded as setting out a specific programme: it is simply a statement of objectives against which shorter term decisions can be made. Very little material progress in the shape of new physical development is to be expected in the next few years. Moreover, the timescale for further significant progress must depend on the general economic situation and has therefore at present to be left open. It will be for Central Government, after due consultation with health and local authorities, to plan on a national basis the use of the funds available within the constraints of the economic situation for the health and personal social services as a whole; and for the matching health and local authorities through joint planning and collaboration to make the most effective local use of the financial resources available to them both. We thus see the next three or four years as a time for health and local authorities firstly to do whatever is possible within the very limited resources available—and there is much that can be done without necessarily using extra money through changes of attitude and more effective use of resources: but also to look ahead and together, on the basis of the policies set out in this White Paper, to agree on what should be done when additional resources do become available. This will mean agreeing for example on which local services should be developed first and which will have to continue, at least for some years, to be based on existing mental hospitals.

BARBARA CASTLE,
Secretary of State for Social Services.

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CONTENTS

Page

CHAPTER 1. THE NATURE OF THE PROBLEM

The considerable problems in defining mental illness and hence in estimating its prevalence. Clinical diagnosis provides one basis for classification. But from the point of view of planning services it may be more relevant to consider ways in which mental illness affects the individual and his family.

The nature and classification of mental illness 1
Mental illness and mental health 1
Estimates of prevalence 2
Classification by diagnostic group 3

The needs of the mentally ill 6
Prevention 6
Early recognition 7
Assessment 8
Clinical treatment 8
Social rehabilitation 8
Help for the family 9
Accommodation 9
Employment 10
Flexibility and co-operation 10

CHAPTER 2. DEVELOPMENTS IN SERVICES FOR THE MENTALLY ILL

Far reaching changes in the pattern of psychiatric care in the 1950s. The underlying theme of these developments integrating the care of the mentally ill with that of those suffering from other forms of illness. While acknowledging that not all the early expectations of " community care " have been fulfilled the Government belief that the aim for the future must still be to provide local, integrated services rather than care based on large specialist institutions. The problems still to be solved. The Government's strategy intended to provide a framework for further experiment and refinement of current policies.

Services up to 1961 11

How far have expectations been fulfilled? 13
Physical and non-physical methods of treatment 13
The " open-door " policy 13
New dilemmas for some patients 14
Projected and present bed numbers 16
The working of the Mental Health Act 1959 16

General policy for the future 16
Validity of the concept of community care 16
The dangers and problems involved 17
A co-ordinated strategy 17
Community involvement 18

CHAPTER 3. TEAM-WORK IN THE NEW PATTERN OF SERVICES

An important aspect of the Government's strategy the development of the right organisational relationships between the various professional and lay groups concerned with the care of the mentally ill at local level. Such team-work essential if the various facilities are to operate as a comprehensive service of treatment and care.

The British Library

Page

The primary care team 20
The specialist therapeutic team 21
Social work staff 22
Volunteers 25
Family care 28

CHAPTER 4. THE DISTRICT SERVICE

The future pattern of services for the mentally ill based on a comprehensive network of health and social services facilities in each district. The guidelines for these facilities are at present tentative and will need to be refined in the light of experience.

Health services 29
The general hospital psychiatric unit 29
Facilities for the elderly 31
Social services 33
General policy 33
Day care 34
Social clubs 36
Residential care 37
Care for the elderly mentally infirm 39
The long term care of the chronic mentally ill 40
Care of people without a home or settled way of life 42
Regional and sub-regional facilities 44
Summary of guidelines for services at district level 45

CHAPTER 5. SECURITY

The district hospital facilities should be able to manage most of the small number of disturbed patients but where greater physical security is required admission to a regional security unit or a special hospital may be necessary.

Treatment in conditions of security 46
Regional security units 46
Secure provision for adolescents 47
Special hospitals 47
Forensic psychiatric services 48

CHAPTER 6. HOUSING AND EMPLOYMENT

In many instances people recovering from mental illness require ordinary housing rather than any specialised residential accommodation. Local housing authorities have an important contribution to make. The wide range of employment and training services provided under the aegis of the Department of Employment and the Manpower Services Commission can do much to help mentally ill people resettle into sheltered or open employment.

Housing needs 49
Employment needs 51
The DRO service 52
Employment rehabilitation 52
Vocational training 52
Sheltered employment 53

The British Library

Page

CHAPTER 7. CHILDREN AND ADOLESCENTS

The continuing and wide ranging discussion about the way in which child and adolescent psychiatric services should be developed. No definitive policy statement in this White Paper. A consultation paper to be issued in the light inter alia of the recommendations of the Court Committee. In the meantime attention drawn to the principal concepts which have emerged from the debate so far.

Children ... 55
The nature of childhood disturbance ... 55
The needs of disturbed children ... 56
Organisation of services ... 57
Adolescents ... 58
The nature of disturbance in adolescents ... 58
Need for psychiatric help ... 59
Organisation and planning of services ... 60

CHAPTER 8. ALCOHOL AND DRUG DEPENDENCE AND MISUSE

Alcoholism and drug dependence present problems which differ in several respects from those presented by mental illness. The current—and increasing—prevalence of alcoholism seems to justify the establishment of a network of services in most health districts with Area Health Authorities acting as a focal point for collecting information and planning. No major changes proposed in services for drug misusers. However since trends in misuse change a flexible approach is important.

Alcoholism ... 62
Prevalence ... 62
Prevention ... 63
Treatment and rehabilitation ... 63
The future ... 65
Drug addiction and misuse ... 67
Background ... 67
Prevention ... 68
Treatment and rehabilitation ... 68
Planning services ... 70

CHAPTER 9. MANPOWER REQUIREMENTS

A significant improvement in the levels of staffing in key disciplines necessary for the successful operation of the new pattern of service. Provisional targets proposed for consultant medical staff and nurses. The further development of training of particular importance for social services staff and others.

Medical staff ... 71
General psychiatry ... 71
Forensic psychiatry ... 72
Child psychiatry ... 72
Adolescent psychiatry ... 73
Training ... 73
Nursing staff ... 74
District psychiatric nursing service ... 74
Targets ... 74

The British Library

Page

Social services staff and their training 75
Psychologists 76
Psychotherapists 77
Occupational therapists 77
Domestic staff 78

CHAPTER 10. RESEARCH AND EVALUATION

Research an essential element in the further development of the Government's policies. The review of research priorities in the field of services for the mentally ill carried out by the Department of Health and Social Security with the assistance of their Chief Scientist's Organisation.

The importance of research 79
Management and research 79
Priorities for research concerned with services 80
Worcester development project 81
Southampton project 82

CHAPTER 11. PROGRESS TOWARDS THE NEW SERVICE

The considerable gap between existing services and the new pattern of service advocated in this White Paper. More emphasis on day hospital treatment, day care, and treatment and support in the home itself and less on inpatient treatment should mean, taking health and social services together, little increase in running costs. But substantial capital investment in new facilities is required and also a shift in the balance of services between health and local authority. In present economic circumstances the next few years seen as a time to make the best use of existing resources, but also for health and local authorities jointly to plan what should be done when additional resources do become available.

The backlog of present deficiencies 83
Public sector costs of introducing the new service 84
Translating philosophy into action 84
The difficulties 84
Resource planning assumptions 85
Joint health and local authority planning 86
Regional strategies 87
Staff involvement 87

APPENDIX. THE MENTAL HOSPITALS IN THE PERIOD OF TRANSITION TO THE NEW PATTERN OF SERVICE.

The British Library

CHAPTER 1

THE NATURE OF THE PROBLEM

The nature and classification of mental illness

Mental illness and mental health

1.1 Mental illness and conversely mental health is notoriously difficult to define. There is now a deep interest in the psychological aspects of human behaviour, collectively as well as individually, an interest which is constantly extending to new facets of everyday life in society. There is growing recognition of the relationship between behaviour and environment; and indeed there are probably few aspects of public and private activity that have not been held to have some effect whether direct or indirect on our psychological well-being. At the individual level there is an increasing readiness to seek counselling, or other forms of professional psychiatric help over an ever wider range of personal psychological problems. As our knowledge and awarenesss of the inter-relationship between physical, emotional, social and environmental factors increases so no doubt this process will continue; more people will seek help and the boundary of what we collectively regard as mental ill health will be set further back. Indeed we must recognise that the potential demand for psychiatric help is virtually unlimited*. We must ask ourselves to what extent such demands are realistic: not only in terms of finance and manpower, for manpower constraints will inevitably impose their own limits, but also in as much as they represent unreal expectations of what psychiatric help can do.

1.2 Changes in the nature of the problems for which individuals consider they need psychiatric help imperceptibly change society's general concept of what is mental illness and what is not; how far behaviour can be regarded as eccentricity and a reflection of individual personality; how far behaviour calls for punishment and how far for treatment. But we should beware of overemphasising this, particularly in the context of current psychiatric practice in this country. It is new advances in scientific knowledge and understanding that have enabled recognition for example of the sufferings of the housebound phobic or the young girl starving herself through anorexia nervosa for what they are—namely the manifestation of mental illnesses for which it is both humane and realistic to offer professional help.

1.3 How do we then define mental illness? On the one hand 'mental illness' as a term probably still has a certain stigma attached to it and most of us probably draw our own fine dividing line between the more comprehensible and respectable forms of mental ill health and the more frightening or distressing forms which we privately label as mental illness. But on this kind of definition the mentally ill would constitute only a small proportion—in practice mainly those with psychotic illness—of the total numbers of those who

*As long ago as 1966 a research study suggested the presence in all communities surveyed of a large sub-group of emotionally sick or emotionally disturbed patients amounting to between 1/5 and 1/10 of the total population.

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are currently seeking and receiving help from general practitioners and psychiatrists for psychological problems of various kinds, from severe depression, and phobias, through a whole range of sexual, marital and other human relationship problems. Equally we have to acknowledge that there are many problems of human behaviour—often causing great distress—for which psychiatry can offer little or no remedy and for which other forms of help and support may be more relevant. Attempted suicide is often a case in point. In recent years the numbers of attempted suicides have risen sharply. Research suggests that only a minority of those concerned suffer from psychiatric illness as such; but often there is a background of longstanding personality and relationship difficulties.

Is mental illness increasing?

1.4 The difficulties involved in measuring the prevalence of mental illness and in particular in making comparisons between prevalence rates in different places and at different points in time will be immediately apparent. The point has already been made both that to some extent society is constantly redefining its concept of mental ill-health, and that advances in scientific knowledge enable us to understand and treat mental suffering which, insofar as it was previously untreatable, was in the past not regarded as illness. These two processes go hand in hand. Surveys of prevalence based on the number of contacts made with relevant health and social services will only reflect the extent to which people in practice seek professional help for their psychiatric or psychological problems. Conversely as and when new treatments are developed and facilities are both readily available and accessible they will themselves call forth new demands. Morbidity surveys run up against the difficulty that they are liable to reflect individual researchers' concepts of mental illness.

1.5 We are tending to widen our definition and our recognition of psychological distress. But is the underlying incidence of such distress also increasing? Are we in fact living in a society which is positively giving rise to mental ill health? There is no hard evidence to confirm that the incidence of mental illness is increasing but undoubtedly there are features of modern industrial society which many people feel make them more vulnerable to mental stress: high rise flats for families with young children; production line work with no job satisfaction; the break-up of the large family unit; overcrowded living conditions; the pressures of advertising with its suggestions of 'norms' of happiness, friendship and sexual satisfaction and the consequent feelings of inadequacy among those who have not achieved them.

Estimates of prevalence

1.6 The second National Morbidity Survey carried out in 1970–71 by the Office of Population Censuses and Surveys surveyed 53 general practices in England and Wales serving some 300,000 people, and found that on average over the year 1 in 14 males and 1 in 7 females consulted their general practitioner for some form of mental illness. This would be equivalent to about 5 million people nationally. However, several recent surveys have suggested that general practitioners themselves may not always detect psychiatric symptoms—or recognise them as such—and there is little doubt that much mental illness, some of it serious, goes undiagnosed and untreated. True need is almost

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certainly much greater than present demand. The proportion of those who consult their general practitioner who are referred to the specialist services is about 12 per cent. It has been estimated that about 600,000 people nationally receive specialist psychiatric services each year. This estimate is based on information from psychiatric case registers which have been established in some parts of England and Scotland and in which all contacts with specialist services from a given population are recorded. But numbers, however great, cannot measure the sum of human misery, the tragic waste to the community of creative talents, drive and enthusiasm and the bitter disruption of family life and relationships which mental illness often brings.

Classification by diagnostic group

1.7 Over recent decades there has been much debate both within and between different professional groups about the nature and classification of mental illness. The increased involvement of a widening range of professions—psychologists, social workers, sociologists, geneticists and biochemists—has led to the recognition of new dimensions of the problem and new theories. What is, perhaps, most encouraging and, indeed, impressive, given the enormous scope of the problem, is that in recent years widespread research has led to a growing consensus of opinion among the different disciplines that mental illness is not the result of any single factor but is caused by a wide range of factors, social, familial, and genetic, and is similarly multi-faceted in its manifestation. Classification is not easy: there is often overlap between some of the generally accepted diagnostic groupings and the severity of symptoms for the same diagnosis varies from one individual to another. Such problems are, however, found in all branches of medicine to varying degrees and are by no means confined to psychiatry. Similarly, as in other fields, a clinical diagnosis by itself will often be of limited significance in determining certain of the patient's needs. But in the field of mental illness there can on occasion be a real danger in giving a patient a diagnostic label, particularly where this is liable to follow him throughout his life and place him on the wrong side of the dividing line between public acceptance and understanding, and public rejection and fear.

1.8 Classification is, however, important. It is the starting point for much comparative research, for investigating the causation of identified patterns of psychiatric disturbance, and it is through informed debate that further knowledge and understanding will be gained. While, therefore, in the following paragraphs mental illness is described on the basis of the Mental Disorders section of the International Classification of Diseases, this is done in full recognition of the limitations of any one approach.

The neuroses

1.9 The principal distinction normally drawn is that between the psychoses and the neuroses. The sufferer from neurotic illness retains his consciousness of the real world about him but certain of his behaviour patterns become exaggerated by fears or depression to such an extent that they interfere with his normal daily life. People with neurotic conditions account probably for more than one-third of all referrals to psychiatric services. Depression and anxiety or tension states are perhaps the most common. The OPCS survey found that during 1970–71 20 males per 1,000 and 47 females per 1,000 attended

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general practice with a diagnosis of anxiety neurosis. The corresponding figures for depressive neurosis were 15 and 47 per 1,000. Depression and anxiety states will vary greatly in degree, in some cases being no more than a relatively short-lived response, perhaps, to bereavement or a new situation, in others severe and prolonged and with no obvious external cause. It should be emphasised that the prevalence of these conditions is much greater than that of psychotic illness.

The psychoses

1.10 The sufferer from psychotic illness, as the condition advances, is distinguished by his tendency to lose contact with his surroundings and his distorted view of the world around him. The largest single group of psychoses are those known as schizophrenia or the schizophrenias. The onset of schizophrenia, perhaps the most disabling of all forms of mental illness, occurs generally in the teens to early adulthood with hospital admission rates being highest among the 25–34 age group. The prevalence rate for adults, in terms of numbers of people in contact with the specialist psychiatric services in any one year, is approximately 1 in 300. Schizophrenia is often accompanied by a withdrawal into a world of fantasy and auditory hallucinations, with disturbance of volition or drive, and as it progresses there may be accompanying physical deterioration. A variant may start with the onset of delusions of persecution. Another group of psychoses, known as affective psychoses, has been estimated as having a comparable prevalence rate of about 1 in 280. They tend to occur later in life and are characterised by changes of mood that cannot be accounted for by external causes alone. The schizophrenias and the affective psychoses are together included in a group of mental illnesses known as the functional psychoses. Though no single theory of causation has yet been established it is possible that they have an inherited biochemical basis, but are precipitated by environmental factors. There is a clearer understanding of the physical basis of a further group, known as the organic psychoses. Acute confusional states may be reversible depending on the associated physical condition. Dementia on the other hand, seen mainly in the elderly, is the result of the death of some brain cells and leads to intellectual deterioration and lack of emotional control and drive. It is an irreversible and generally progressive process, the prevalence of which has been shown to increase greatly among persons in their late seventies and eighties.

Psychopathic disorder

1.11 The Mental Health Act 1959 defined psychopathic disorder as " a persistent disorder or disability of the mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient and requires or is susceptible to medical treatment ". The term " psychopath " has come to carry considerable stigma and there has been a reaction against it in favour of "personality disorder with antisocial trends " since this is thought to convey a better idea of the range of problems involved. Personality disorders affect people of a wide intelligence range, and seem to be inherent personality traits rather than illnesses as such. Those with personality disorders have in some cases an apparent lack of ordinary appreciation for the feelings of others, and a common characteristic

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is an inability to learn by experience. They are often considered as having an immaturity of personality which may manifest itself in many different ways: at one end of the spectrum they may be highly disruptive members of society and commit serious crimes. At the other it may result in no more than an inability to organise a settled life, often with a consequent tragic descent down the social scale. The individual's basic difficulty in coming to terms with society may, however, manifest itself in many ways each in some way an attempt to resolve his apparently insoluble problems.

1.12 There is considerable uncertainty about the extent to which people with personality disorders can be helped by the mental health services and there is undoubtedly a need for further research and new approaches in this field. It is generally accepted that such people do not readily respond to traditional psychiatric treatment and indeed there are difficulties of principle in determining those cases in which it is proper to regard a behaviour pattern as a " disorder ". Nonetheless in recent years there has been a sharp increase in the number of admissions to hospital for personality and behaviour disorders. People with serious personality disorders not infrequently become involved with the Police. They also present considerable problems for social services departments. There has recently been much debate as to whether, and if so to what extent, it is appropriate for them to be admitted compulsorily to psychiatric hospitals. The present position is that the concept of susceptibility to medical treatment is applied to compulsory admission; and this has led to difficulties in certain areas in the placement of psychopaths appearing before the Courts. The question of psychopaths who offend against the law has been studied by the Committee on Mentally Abnormal Offenders, chaired by Lord Butler, which has recently completed its report.

Alcoholism and drug addiction

1.13 Alcoholics and drug addicts can be seen as those whose repeated and excessive use or misuse of alcohol or drugs has led, whether singly or in combination, to social, psychological, or somatic harm including the development of dependence. Dependence may be physical and it may be psychological and has elements, therefore, of both compulsion and habit. A difference from the illnesses described above is that the availabliity of the " agent ", be it alcohol or drugs, as well as social, cultural, personality and physical factors may have contributed to its growth. Alcoholism and drug dependence are not mental illnesses in themselves, though some mental illness may accompany them or arise as a consequence; the psychological component in dependence is commonly treated by or under the general direction of a psychiatrist. No account of the psychiatric services would be complete without some account of the services needed by those who are dependent on alcohol or drugs, or who harm themselves by misusing them.

Distinction between mental illness and mental handicap

1.14 Mental illness is quite distinct from mental handicap. Mental handicap is usually determined before or during birth or in the early weeks of life and is characterised by intellectual retardation which affects the ability to learn and reason. It may be accompanied by physical and psychiatric handicaps. Though the development of the mentally handicapped person can be improved by

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training, education and social care, mental handicap cannot be cured and is a life-long condition. Mental illness, however, can occur at any age and affects people of every intellectual level. (Some mentally handicapped people also suffer from mental illness.) While in the present state of medical knowledge by no means all forms of mental illness can be completely relieved, advances over the last 20 years mean that most functional illnesses will now respond to treatment.

The needs of the mentally ill

1.15 These clinical labels reveal relatively little about what it means to be mentally ill or to live with someone who is so afflicted, or by implication what the needs of the mentally ill are in terms of services. In one sense it is misleading to attempt any generalised statement about the needs of the mentally ill. The needs of any one mentally ill person are always different from another even though they may have the same diagnostic label. It is not merely that need depends on factors such as age, whether there is home support or a sympathetic employer, but rather that the manifestation of the illness itself will to some extent be coloured by the personality and home environment of the individual. Viewed from the individual level, need is personal and it is important that those working with the patient should see his problems in this way. At the same time these individual perspectives should not mask the significance either of the clinical factors whose identification is fundamental to scientific classification, or of those needs for certain kinds of help which the mentally ill have in common, which are discussed below, and which form the basis of any attempt at national or local planning of services for them. We must aim, therefore, at a range of facilities which can be used by professional staff to provide for each individual the particular combination of care, treatment and support he needs at any point in time.

1.16 Not only does need vary qualitatively between different individuals, it varies quantitively, especially in the length of time for which support and treatment may be required. Much emphasis has been laid, and rightly, on the revolution which has taken place in the treatment of the mentally ill in recent years. This has meant that for many mentally ill people, psychiatric treatment need mean no more than a spell of out-patient or day patient visits or a very few weeks as an in-patient. Nevertheless, there will remain some people who, although their more acute symptoms can be relieved, will need more or less permanent medical, social and nursing support in a sheltered environment. While this group may be relatively few in number their needs must be recognised, especially as the implications in terms of resources are quite disproportionate to their numbers. Another important group are those with mental illness symptoms related to old age. Increasing longevity is bringing its own problems in this respect.

Prevention

1.17 In the absence of more precise knowledge primary prevention can only be considered in the rather broad terms of reducing the exposure of individuals to those circumstances and conditions which are likely to place their mental health at risk. Healthy physical, mental and emotional development in childhood is obviously particularly important. Reference has been made

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already to the wide range of social and environmental conditions which may increase vulnerability to mental illness. The precise weight to be attached to them can rarely be established: poverty, unemployment, lack of job satisfaction and poor working conditions, bad housing, are themselves often a cause of marital stress and breakdown in family life. For some of these central and local authority has a responsibility: but it would be wrong to pretend that we are anywhere near being able to draw up a positive plan for a society conducive to mental health.

1.18 Nevertheless we can take some steps to put right some of the clearly unsatisfactory aspects of our social environment. In the field of employment for example, the Employment Medical Advisory Service of the Health and Safety Executive has created a senior appointment in mental health to examine the problems of stress in modern industrial life and offer advice to industry and the unions. It is anticipated that a small team of specialists will be available to undertake surveys and studies, and arrange for appropriate research work with outside bodies such as the Medical Research Council. In this area, the Employment Medical Advisory Service will co-operate closely with the Work Research Unit of the Department of Employment, set up in 1974 to assist organisations in taking practical steps towards increasing the quality of working life by improving the design of jobs and organisation of work. Similarly in its approach to housing problems the Government has taken steps, notably through the Housing Act 1974, to ensure that resources are concentrated on the areas of greatest stress.

1.19 Employers, managers, environmental planners all need to bear in mind the potential impact of their decisions on people's mental well-being. The lessons of high rise flats are an illustration; and it is to be hoped that local housing authorities in particular will increasingly take into account the question of mental health when considering the effect of new developments on existing communities. Rarely will there be easy answers, but it is a dimension of planning which should be acknowledged.

1.20 The growth of a wide variety of community development and self help schemes, clubs and societies is particularly encouraging. Such organisations can provide a whole range of sources of help which though perhaps not specifically directed at mental health have an important part to play in providing those at risk with additional pyschological or social resources. Marriage guidance, vocational guidance, clubs and recreational facilities, church and voluntary organisations, education for leisure and retirement, are all relevant. Organisations and services which are specifically aimed to help in particular crises such as marital breakdown, pregnacy, bereavement, retirement or redundancy are of special importance. Collectively and individually we each have a responsibility to be sensitive to the emotional and psychological needs of those who are vulnerable.

Early recognition

1.21 The individual himself may be unaware of his condition. Those around him and even professional staff may not recognise it initially. Mental illness may often be hidden beneath a wide variety of presenting problems: an ostensibly physical complaint, marital and family problems, quarrels with neighbours, accident proneness at work and delinquency may all have their

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roots in mental illness. Moreover sometimes the person for whom help is apparently sought may not be the only one in need of professional support: the parents, for example, of a disturbed child may themselves require psychiatric help. Services must be organised and professional staff trained to recognise the early stages of psychiatric disturbance and to arrange referral to the appropriate services. Early intervention may often serve to prevent the condition deteriorating to the point at which a severe crisis occurs and hospital admission becomes the only possible solution.

Assessment

1.22 Assessment of needs must take account of the effects of mental illness on almost every aspect of a person's life. It should be a continuing process involving all the professions concerned, aimed at reducing as swiftly as possible the damaging effects of illness. The importance of multiprofessional assessment lies not least in the interchange of views between assessors. Not only is this essential in the development of an accurate, broad based assessment but the assessment by each individual discipline is often influenced by those of others.

Clinical treatment

1.23 General practitioners working with other primary care staff at present undertake the medical treatment of nearly 90 per cent of diagnosed mental illness and it seems unlikely that this pattern of care will change significantly. It is, however, important that those people who need specialist treatment are accurately identified and promptly referred to specialist services. Equally, it is important that specialist help should be readily available to the primary care teams.

1.24 For those who require specialist medical and nursing care and treatment, facilities need to be available locally; and these need to be designed to enable both physical and psychological forms of treatment to be practised. A local service means that patients can easily attend as day or out-patients and professional staff can be on the spot to help patients and their families. In some cases admission to hospital as an in-patient will be necessary, either because the illness warrants 24-hour medical and nursing supervision for a time or because the home circumstances are so intimately connected with the illness that a move from the home is an essential step for objective assessment. In general, however, the need for in-patient treatment is declining. So also is the need for treatment to be given under conditions of physical security. Contrary to general public belief, the most serious forms of mental illness are rarely associated with aggression although they may give rise on occasion—and for short periods—to behaviour which is distressing and perhaps frightening to the layman. Nevertheless it is important that the need for treatment under secure conditions, although for a relatively small number of patients, should be recognised and provision made accordingly.

Social rehabilitation

1.25 Mental illness often fundamentally affects social adjustment, even after the primary symptoms of the illness have been treated. The sufferer may lack his former energy and drive; and have difficulty in making or resuming

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personal friendships or family relationships. He may have lost the power of sustained concentration; and the ability to organise even relatively simple daily routines may have to be relearnt. If he is to resume his place in a busy competitive society he will need help in regaining social skills which in the ordinary fit person are taken for granted. The loss of such skills even for a short period of time may have far reaching repercussions. A person recovering from mental illness may well not be able to bear the full responsibility of organising his life.

1.26 Social rehabilitation has also to be considered from the standpoint of the community in the wider sense. The pace of development of community services for the mentally ill is dependent partly on changes in attitude by the community. It is also dependent on the community's capacity to adjust to the implications of community care for other groups—for example, the mentally handicapped, the physically handicapped, the elderly mentally infirm. We must ensure that the community is not itself overwhelmed.

Help for the family

1.27 Living with people who have had or who are recovering from mental illness can place heavy strains on a family. The mentally ill do not always fit easily into the family circle or adapt to the family routine: meal times, social activities, entertaining may be disrupted and the family can rapidly become socially isolated. If the mother is ill, the father may find himself having to take time off work and the family income may fall. Special arrangements may need to be made for the care of the children. Research studies have already shown that the children of mentally ill parents are themselves more likely to suffer from mental illness. The family may become afraid to leave a withdrawn and uncommunicative member alone; and they too may become virtually housebound, often giving up sources of income and interest. Under such stresses the family may become torn between their determination not to reject the individual member, and a desperate need for relief and support. Feelings of guilt may be accentuated where there are brothers or sisters living at home, competing for their parents' attention and resentful of the way in which their own lives and friendships are disrupted.

1.28 Some families may be able—and indeed wish—to undertake the demanding task of care. But in these cases it is essential that they receive support and advice from professional staff and that services should be organised to give them effective relief: to enable them to go on holiday and to cope with more urgent domestic crises which may make continued care impractical from time to time, or simply to allow them some respite from the sheer physical and emotional strain.

Accommodation

1.29 For some families this strain may prove quite intolerable. In other cases, although the family is willing, it may be that—at any rate for a time—taking his place again within the family will constitute too severe an emotional and psychological strain on the individual himself. Sometimes, moreover, the patient has no home to return to. An important requirement must therefore be to provide alternative arrangements so that a persons who is or has been mentally ill can have the equivalent of a secure home and the company of others.

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The support of professional staff may be needed where he is able to cope with only a limited number of the complexities of daily life. Without such support he may neglect himself, become isolated and withdrawn, and his mental and physical health may deteriorate.

Employment

1.30 Mental illness sometimes results in an impairment of an individual's ability to occupy himself in a constructive way and in the more formal sense to pursue his normal employment. He may be unable to keep regular hours, to deal with colleagues or staff, or to keep up an adequate output under pressure. Many people can redevelop their capacity for work but they will need training facilities and help in finding employers sympathetic to their needs. During their illness they will need help and encouragement so that the rhythm and discipline of working, and the ability to occupy leisure time are not lost. Those who are left with a residual disability making them unable to return to their former field of employment need to be given the opportunity to learn new skills suited to their new situation.

Flexibility and co-operation

1.31 The above paragraphs have referred briefly and in general terms to various needs. Later chapters describe the services which are envisaged to meet them. They involve many professional disciplines and a number of different statutory authorities. The individual client or patient and his family cannot however be expected, particularly at times of severe psychological strain, to analyse the complexity of pressing clinical, financial, domestic, housing or employment problems into watertight compartments relating to different authorities. The hallmark of a good service for the mentally ill is a high degree of local co-ordination. The organisation of services in the future must be sufficiently flexible to enable them to identify and respond to widely varying individual needs for care and support, yet with areas of responsibility, and lines of communication sufficiently clearcut to enable action to be taken quickly and effectively. It is particularly important that patients should be able to move easily between different parts of the service—from hospital to residential and day care—and if necessary back to hospital again. At all times, the individual and his family should feel that they are dealing with a single integrated service.

1.32 The individual and his family must also be made to feel that they themselves have a positive contribution to make to the whole process of treatment, care and rehabilitation. They should be encouraged wherever possible to discuss with the professional staff involved the various needs and the way in which these might be met. The patient's family is often anxious and willing to help and should be given every opportunity and encouragement to do so.

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CHAPTER 2

DEVELOPMENTS IN SERVICES FOR THE MENTALLY ILL

Services up to 1961

The Victorian inheritance

2.1 The facilities we have at present to serve the mentally ill are largely an inheritance bequeathed to us by the Victorians. Of the 100 or so hospitals providing treatment solely for the mentally ill now in existence, most were built in the nineteenth century and some have an even longer history. Most are very large—a number were built to accommodate 2,000 or more patients; and were deliberately built in areas which were then, and in many cases still are, isolated and remote from centres of population. The aim was twofold; partly to protect society by providing custodial care behind locked doors and high walls and partly to protect the patient by providing him with a secure shelter. A remote site in the country was therefore desirable on both counts, and had the added advantage that it enabled many patients to have the benefit of wholesome work in the open air. In an era which lacked modern medicine, had but the most rudimentary welfare services and no system of social security payments, the large mental hospital was designed to be as far as possible a self-sufficient community meeting the patient's need at once for care and custody.

The drugs revolution of the 1950*s*

2.2 From the time these hospitals were built and right up to the year 1954, the number of resident patients in mental illness hospitals went on steadily increasing save for a small temporary reduction during each of the two World Wars. No new mental illness hospitals were however built after the 1930s and by the early 1950s many were becoming severely overcrowded. Serious thought was then being given to the need to build new mental hospitals; but fortunately the first half of the 1950s saw major developments in drug treatment, in particular with the drug group known as the phenothiazines. The particular significance of these drugs lay in the fact that they enabled doctors to control the disturbed behaviour of the psychotic patient. As a result not only was the need for locked doors greatly reduced, but it was also possible for doctors and nurses to develop contact with patients who had hitherto been almost entirely cut off from the real world around them by their psychotic illness. These drugs did not cure illness: but they did enable symptoms to be controlled and relieved and hence made it possible to prevent or at least reduce to a considerable extent the social and personal deterioration accompanying prolonged psychotic illness. The discovery of the phenothiazines, and more recently the long acting derivatives, was important but one should not underestimate the significance of other developments: changes in staff attitudes; the introduction of non-physical approaches to treatment; the development of social security and other forms of support outside hospital. Together these

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developments led to what has been called the "open-door" policy. The function of the hospital was seen increasingly as being for treatment and rehabilitation rather than care and control. With the growing realisation that so many patients could be treated as day patients or out-patients, admission for long term in-patient treatment became less necessary. This changing approach also led to the development of small psychiatric units in general hospitals for treating some mentally ill people locally, instead of at large distant specialist hospitals.

The Royal Commission of 1957 *and the Mental Health Act* 1959

2.3 The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, and its legislative sequel, the Mental Health Act 1959 gave formal recognition to the fundamental change in approach which was taking place. The Act made far-reaching changes in the procedures for admission to a mental hospital: for the great majority of patients, admission for psychiatric treatment now entailed no more formality than admission for any other form of hospital treatment. This emphasised the hospital's role as a place for treatment and not merely custody. Directions under the National Health Service Act placed new duties on what were then the health departments of local authorities to provide for the care and after-care of mentally ill people outside hospital.

Projections of declining numbers of in-patients

2.4 By the end of the 1950s the repercussions of the new forms of treatment were being dramatically reflected in hospital bed numbers. From 3·4 per 1,000 population in 1954, the number of occupied beds had already fallen to 3·1 per 1,000 by 1960. Projections made in 1961* by Statisticians at the General Register Office suggested that in the future some 0·9 beds per 1,000 population would be needed for patients staying less than 2 years; and that a further 0·9 would be required for newly arising longer stay patients. The projections further suggested that none of the patients then in hospital would still be there in 15 years or so. The 1962 Hospital Plan† recognised the place of the short-stay psychiatric unit as a part of the general hospital and envisaged that many of the existing mental hospitals would have no place in the new pattern of service.

The underlying movement to community care

2.5 The underlying movement was becoming clearly discernible, namely of bringing into closer relationship services for the mentally ill whether in hospital or outside it, with services for other forms of illness and handicap. Psychiatry was coming in out of the cold. The report of the Royal Commission commented: "The mental health services would lose much more than they could gain by a return to isolation and separation, and it would be most unfortunate if schemes for co-ordination between hospitals and local authorities were not to be accompanied by correspondingly close contact with other parts of their own services".

*Lancet, 1st April 1961, p. 710.

†Hospital Plan for England and Wales, 1962, Cmnd 1604.

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How far have expectations been fulfilled ?

2.6 It is now some 15 years since this watershed. How far have hopes been fulfilled: how far frustrated and disappointed? The process of integrating psychiatric with general hospital and community services has gathered strength. There are now a considerable number of general hospital psychiatric units—although varying considerably in size and adequacy of accommodation. There is greater emphasis in undergraduate medical education on psychiatric illness. Only one of the provincial medical schools lacks an Academic Department of Psychiatry. There are however still no such Departments at four of the London medical schools. Social work support and services for the mentally ill are now an integral part of the responsibility of local authority social services departments. The process has not always been smooth. The case, for example, for the integrated social services department was hotly debated. Both in the medical and social work fields those concerned with the mental illness services still face the very real dilemma of wanting the benefits of integration, yet wishing to retain the different approach to therapy that mental as distinct from physical illness so often requires; of wanting to be an integral part of the general pattern of health and social services facilities, but yet wishing to ensure that the special additional needs of the mentally ill are recognised and provided for.

Physical and non-physical methods of treatment

2.7 Drug treatments continue to be widely used, and have played a major part in facilitating the decline in length of in-patient stay for many patients, and the rapid growth of day and out-patient treatment. It has to be recognised, however, that research has still not shown the precise mechanism by which these drugs have their effect. Some argue that drugs are used too much—particularly in the treatment of neurotic illness; that they treat symptoms only and ignore underlying social, psychological and environmental causes of mental illness, for which psychological methods are more appropriate. In particular some stress the importance of family and personal relationships as a factor in causing mental illness and argue that treatment must take account of this. There are those who argue that often it is society or the family which is disturbed rather than the individual patient. Others are equally convinced of the importance of biochemical factors in causation and argue that from this viewpoint drug treatment is the logical remedy. The issues are widely discussed and debated; but what seems beyond doubt is that mental illness is a highly complex phenomenon, taking many forms and caused by a variety of different factors. In recognition of this, the great majority of psychiatrists deliberately adopt an eclectic approach to treatment. While the choice of treatment is a matter for professional judgment, the patient and his family have to find the choice acceptable. Although what doctors say to individual patients about their illness must be a matter for clinical discretion, there would seem to be much to be said, as a matter of principle, for accepting the need to explain to the patient and his family the nature of the illness and the doctor's particular approach to its treatment.

The " open-door " policy

2.8 In one sense there has been very considerable progress towards community based services, in that the great majority of psychiatric hospitals and units increasingly see themselves as serving a population that extends far beyond

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the hospital walls. Out-patient attendances number 1½ million a year, day patient attendances 2 million. Psychiatric nurses are working more and more with patients and their families in their own homes. But by and large the non-hospital community resources are still minimal, though where facilities have been developed they have in general proved successful. The failure, for which central government as much as local government is responsible, to develop anything approaching adequate social services is perhaps the greatest disappointment of the last 15 years. As a result the balance of existing facilities—health and social services—bears increasingly less relation to acknowledged needs. Hospital staff have, rightly in one sense, come to see their role as an active therapeutic one and the hospital as a place for providing medical treatment and nursing care. So they have become increasingly unwilling to act as social care custodians for those who would not need to remain in hospital were supporting facilities available in the community. But we have to face the fact that adequate supporting facilities in the community are not generally available. For many years this will pose a continuing problem to which there is no easy answer and it places on the staff of the mental hospitals very real frustrations. Much of their effort in the past has been directed to developing intensive treatment and rehabilitation leading to discharge back to the community. Largely as a result the gross overcrowding of earlier years has in general been considerably reduced. Naturally they wish to see further progress in this direction. Clearly people should not be admitted to hospital who have no need for treatment; but admission and discharge policies must be realistic and take account of the local availability of supporting social services. If they do not, they put at risk the whole principle of community care in the eyes of the public. The Government for its part intends to see that over the years the balance of health and social services is put right.

2.9 The frustrations and dilemmas of this situation have been felt no less by the great majority of local authorities who have been anxious to develop their services for the mentally ill, but who have been constrained by the limits on resources and the increasing and competing demands for new developments throughout the whole social services field.

2.10 The term " open-door hospital " has, like " community care " become with time something of a catchphrase. Such phrases tend to acquire an over-simplified meaning and it may be worth examining what this concept means in terms of present day psychiatry. It should clearly be regarded as signifying an approach to treatment rather than a factual description of the physical arrangements at the hospital. Wards may be unlocked but professional judgment needs to be exercised as to whether a particular patient at a particular time should not be sufficiently supervised at least to prevent his leaving the hospital and abandoning his treatment. The extent to which physical security is needed is a separate issue discussed in Chapter 5, but adequate supervision of the relatively few patients who require it, is important for public trust and confidence in the overall pattern of care.

New dilemmas for some patients

" *Difficult* " *patients*

2.11 The emphasis on " open door " and active treatment and rehabilitation has brought inestimable benefit for the vast majority of patients. The question

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must, however, be asked whether these developments which have so benefited the great majority, have not produced new dilemmas in relation to the care and treatment of certain minority groups and led for example to a polarisation between the " open " system on the one hand and the " security " system on the other. In recent years for example some psychiatrists—and nursing staff—have become increasingly reluctant to accept in " open door " hospitals or units patients with difficult behaviour problems. Such reluctance, moreover, extends not only to patients whose behaviour is continuously difficult, but sometimes also to patients who exhibit only occasional minor violence. The reasons for this reluctance are complex. In some cases staff shortages may genuinely make it impossible to manage a frequently violent patient; whereas for the persistently difficult patient requiring continuing physical security the problem may be one of providing security in circumstances in which it is not required for the other patients.

2.12 There may also be reluctance to admit as a patient someone who not only disrupts the treatment of others but for whom the professional staff may have little to offer in terms of treatment. Often such patients have a long history of repeated admissions to mental hospitals; often they discharge themselves after only a day or so in hospital, perhaps only to end up in court or as vagrants, or after a varying interval to return themselves to hospital. One can understand the wish not to admit to hospital a person whom the staff have repeatedly tried to help without apparent success. But the public understandably become concerned when people who are clearly inadequate or behaviourally disturbed are refused admission to hospital and end up for example in prison. The Government has great sympathy with this concern; and believes that until the right supporting social services can be developed the health and social services must accept a joint responsibility for the care of these people and offer such help as they can. It should, perhaps, be emphasised that repeated admissions should not necessarily be regarded as indicating failure on the part of the health and social services. Although in some cases it may well be true that inadequate treatment or follow-up results in relapse and the " open door " becomes a " revolving door " there are people whose needs are best met by a series of relatively brief admissions aimed at managing particular episodes of disturbance.

2.13 What is required is a service which is flexible and capable of dealing at local level, wherever possible, with the difficult behaviour and violence which may occur from time to time during the treatment of particular patients. The aim should be to keep the use of special " security " provision to the very small minority of patients who cannot otherwise be safely catered for. It is necessary both to bear in mind the interests of the surrounding community and the need to prevent unnecessary restrictions on individual liberty. What is required is a range of provision, from the informal and open to the formal security units and special hospitals.

Those with chronic illness

2.14 The numbers of difficult and violent patients are relatively quite small. A more substantial minority group are those with chronic psychiatric illness, such as some forms of schizophrenia, who require long-term treatment, care and support. Those who require continuing care, though not necessarily medical or nursing care are particularly vulnerable to the present virtual total

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absence of long-stay sheltered accommodation in the community. Moreover, those who do need very long-term medical and nursing care need a different environment and a rather different pace and tempo from those staying for shorter periods. Much effort was put into the rehabilitation of the long-stay patient in the 1950s and 60s. Unfortunately, there was in practice rarely any possibility of discharge to the community, and this, combined with the growing demands and interests of acute psychiatry, has sadly tended to diminish interest in this field—requiring as it does infinite patience, perseverance and generous staffing. We need to revive the interest in meeting the needs of long-stay patients in a way which is challenging and satisfying for both staff and patients, and which integrates such care with that of the shorter stay patients, instead of regarding it almost as a separate and often second-tier service.

Projected and present bed numbers

2.15 It may be useful to assess the 1961 General Register Office projections in the light of experience (see paragraph 2.4). The number of beds used for patients staying up to 2 years is now close to the projection of 0·9 beds per 1,000 population and the number of beds for longer stay patients who have been admitted since 1961 is also close to the projection for that group. The main difference between the projections and what has actually happened is that a substantial number of the long stay patients who were in hospital in 1954, the data base used for the 1961 projections, are still there. In 1971 some 30,000 of the original 110,000 were still in hospital and these numbers are only slowly declining. Almost a half were still less than 65 years old.

The working of the Mental Health Act 1959

2.16 It is generally accepted that the balance which the Mental Health Act struck between the liberty of the individual and the needs of patients and of the public for protection has proved to have been well judged. There have been criticisms from opposing directions, on the one hand that it has become too easy for patients to leave hospital and on the other hand that the powers of detention are still too extensive, but such criticisms have been few and in general the Act has been well received. Developments in care and changes in public attitude since 1959 have not been such as to suggest that there is any need for a major reappraisal of the law of the kind that was undertaken by the Royal Commission. We do, however, need to look critically at the detailed working of the Act. The Department of Health and Social Security hopes to issue later this year or early next year a consultative document taking account of comments received from the bodies which have been looking at the working of the Act and the recommendations in the report of the Committee on Mentally Abnormal Offenders. This consultative document will set out provisional views on the extent to which amendment is called for and the Government will then frame its legislative proposals in the light of further comments received.

General policy for the future

Validity of the concept of community care

2.17 Before, therefore, we make substantial new investment in services for the mentally ill, we are bound to ask whether the failures and problems of

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the last 20 years render invalid the concept of community orientated care and treatment. We believe that the failures and problems are at the margins and that the basic concept remains valid. We believe that the philosophy of integration rather than isolation which has been the underlying theme of development still holds good; and that for the future the main aims must continue to be the development of much more locally based services, and a shift in the balance between hospital and social services care. We believe, moreover, that there is a very substantial measure of professional support for these objectives. At the same time we must face up to the problems involved and the need to find satisfactory solutions to them.

The dangers and problems involved

2.18 There is the danger firstly that psychiatric units in general hospitals may tend to be too selective about the patients they admit and that this could exacerbate the problems of care for the minority groups, problems already apparent within existing services. It points up the inherent contrast between the concept of providing a wide range of services on a single site, capable of responding to different and changing individual needs for treatment and care, but necessarily, because of this range, taking the form of a large and somewhat remote institution; and the concept of providing a network of smaller but local services acting as an integrated whole. The mental hospitals by virtue of their size have been able to offer a range of facilities on a single site and have some staff always available. The price to be paid is in terms of geographical isolation of staff and patients alike.

2.19 The second danger is that the mere fact that a service is local does not of itself make it a service integrated with the community. Integration is not simply a matter of geographical location. A hostel in the heart of suburbia can be inward-looking and institutionalised if it does not function as part of a wider service, and if it does not have staff with appropriate training.

2.20 Thirdly a strategy for the development of local services and the future of the large mental hospitals must inevitably be a long-term one and obviously has to have regard to the availability of resources. Uncertainty about the future has already hung over these hospitals since the 1962 Hospital Plan. While the need for long-term objectives has to be recognised, this factor of uncertainty emphasises the importance of providing realistic plans for the shorter and medium term which will identify which hospitals are likely to be phased out relatively quickly, which will have a reduced role, and which will have a continuing major role in the longer term.

2.21 Fourthly our planning must take into account the prospects of securing the growing weight of expenditure that will be necessary on the part of the local authorities if we are to have any realistic hope of achieving the necessary shift towards the relevant community services.

A co-ordinated strategy

2.22 The following chapters set out the Government's broad policy objectives. The first is an expansion of local authority personal social services to provide residential, domiciliary, day care and social work support. The second is the relocation of the specialist services in local settings. The third is the establishment of the right organisational links: between area social work teams

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and the social work staff in day centres and residential care, and between the multi-professional therapeutic teams and the primary care services; between the health service and local authority social services administrators and planners; between professional and lay people. The fourth is a significant improvement in staffing to enable individual patient needs to be assessed and reviewed on a multi-professional basis and to provide for earlier intervention and preventive work. A co-ordinated strategy meeting all four objectives should minimise the risks of fragmentation and selectivity. The way and rate at which these objectives, and particularly the first three, are achieved will vary from area to area.

2.23 There are no easy solutions. The Government hopes that this White Paper will both give the necessary impetus to the general development of community orientated services and at the same time provide a basis for further discussion, experiment and research in the problem areas.

Community involvement

2.24 The statutory services, no matter how comprehensively they are planned, cannot by themselves provide a complete answer to the needs of mentally ill people. The general aim of enabling the mentally ill to participate as fully as possible in the life of the community will only be achieved if other members of the community recognise and support it.

Public attitudes

2.25 Popular fears of mental illness have deep roots and the spread of greater tolerance and understanding can only be a gradual process. There has nevertheless been a steady increase in awareness that mental illnesses are illnesses, that people recover from them and that the process of recovery is influenced by the level of help and understanding shown to the mentally ill by those around them. This development undoubtedly owes much to the way in which the role of the health and social services has itself evolved in recent years, with more and more people returning to ordinary life after a relatively short period of psychiatric treatment. The relationship between the mentally ill and the rest of society cannot however be taken for granted, as something which will sort itself out in the wake of further improvements in statutory services. A humane service for the mentally ill requires the active concern of ordinary people as well as their tolerance. The success of rehabilitation depends in part on relationships with a wide range of private and public agencies—employers, housing and other local authority services and social security and other central government offices. The people who work in such agencies are themselves ordinary members of the public and their capacity for sympathy and understanding is inevitably a reflection of the way in which mental illness is perceived by the community at large.

2.26 Whether much can usefully be done to influence public attitudes directly is uncertain. There is however a great deal which health and social services authorities can do to encourage people who are actively concerned about the problems of the mentally ill and want to give help themselves. This is discussed further in Chapter 3.

The responsibility to the community

2.27 Those who work in the health and social services fields have to recognise that families and relatives, and indeed the public at large cannot be expected to

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tolerate under the name of community care the discharge of chronic patients without adequate arrangements being made for after-care and who perhaps spend their days wandering the streets or become an unbearable burden on the lives of their relatives; hostels which are so selective that they are only half full while people needing residential care are told they are unsuitable; appeals which go unanswered for help in crises while authorities or professional officers debate boundaries of responsibility. Such situations do not occur very frequently: but where they do, the whole concept of community care is placed at risk. The development of community orientated services depends on a two way responsibility: on the community as a whole to educate itself about mental illness, to extend its sympathy from the minor psychological problem to the more severe illness; and on all those concerned with the care and treatment of the mentally ill not to attempt to implement policies that depend on community tolerance faster than the community can adjust to them. The care that is taken with the relatively few, and more difficult patients, is the guarantee of acceptance for the majority.

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CHAPTER 3

TEAM-WORK IN THE NEW PATTERN OF SERVICES

3.1 A number of different elements make up the comprehensive network of services envisaged in the new pattern. It is however the building up of team-work and close relationships between professional staffs and lay groups that turns facilities into a working and comprehensive network of services.

The primary care team

3.2 The general practitioner's role both in treatment and in secondary prevention of psychological disturbance is already expanding. Although a number of agencies may be involved in bringing mental illness to notice—in particular the Employment Medical Advisory Service and in the case of young people, the school psychological service—it is to the general practitioner that the sufferer or his family are still likely to come for help. The general practitioner moreover will not always have to rely solely on his own personal knowledge of the family to help him to identify underlying psychological problems of which the patient himself is perhaps unaware. He will increasingly have the pooled knowledge of the members of the primary care team.

3.3 The health visitor and home nurse both have special responsibilities, for example to the elderly, and in the course of their domiciliary visits may detect signs of confusion or self-neglect suggesting the onset of mental illness. The health visitor through her regular links with families with young children is able both to see a child's behaviour at home among the family and hence to give early warning of a possible need for psychological help for the child and also to be alert to signs of emotional disturbance or mental illness in other members of the family. A social worker attached to a primary health care team is well placed to contribute to the identification of social and psychological problems and the assessment, diagnosis and rehabilitation of the patient; and also to act as a link with the resources the community can offer. With their combination of professional skills and first hand experience of the individual, the home and the family, the primary care team can do much to ensure early recognition and referral for specialist treatment.

3.4 With the changing pattern of services many more mentally ill people will in future be living in the community, perhaps attending hospital on an out- or day patient basis or between spells of in-patient treatment. The primary care team have an important collective contribution to make to the care of such patients, not only by playing an appropriate part in treatment, but by keeping in close touch with patients who are prone to relapse, by helping their families to understand the nature of the illness, and by alerting the specialist services if the patient's condition or the family situation shows signs of deterioration. If they are to fulfil this role it is essential that they have the advice and support of the specialist team.*

*see further paragraphs 3.7–3.9 below.

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The specialist therapeutic team

A multi-professional approach

3.5 Multi-professional team work is of the utmost importance; and this has led to the concept of the specialist therapeutic team. A specialist therapeutic team would for example include psychiatrists, nurses, social workers*, therapists involved in occupational and recreational activities, and psychologists.

3.6 The consultant psychiatrist normally has responsibility for ensuring that the needs and progress of each patient are regularly reviewed and that other members of the team are involved in these reviews. At the same time each individual member has responsibility in his own particular sphere for assessing progress and bringing to the notice of others in the team any developments which seem to call for a wider multi-professional review. This is not to say, of course, that every member of the therapeutic team will need to be involved with every patient, or indeed that every patient either needs—or would be willing to accept—a team approach to what he may feel are intensely private problems. It is however important that staff should recognise the potential value of multi-professional working and be ready and willing to adopt this approach wherever it is in the patient's best interests. The roles of the individual members of the team, in particular the consultant psychiatrist who has clinical responsibility for treatment are discussed more fully in Chapter 9. These roles often overlap: in some situations personal skills may be more important than professional background.

Relationship with primary care team

3.7 The members of the specialist team need to be readily available for advice and consultation to colleagues in other disciplines who may have patients with psychological problems. Such relationships are of course long established between consultants and general practitioners though here too there is scope for further development as manpower resources permit. The importance of psychiatric advice for patients under the care of consultants in general medical and surgical wards is becoming increasingly recognised. A physical illness may well complicate a psychiatric disorder and vice versa. This is especially so, for example, in elderly patients and alcoholics. Relationships between the disciplines concerned with physical illness and those concerned with mental illness will be strengthened by basing specialist psychiatric services in the local general hospital.

3.8 A parallel relationship to that between the psychiatrist and his medical colleagues is developing between the psychiatric nurse and her colleagues in general hospital and home nursing. The psychiatric nurse is able to provide a direct service of advice to nurses and health visitors working in the community or to nurses in other parts of the general hospital.

3.9 The specialist team should be equally willing to seek the advice of others—particularly primary care staff—in considering the overall needs of individual patients in their care, especially over arrangements for discharge from hospital.

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*see further paragraph 3.27 below.

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CHAPTER 3

TEAM-WORK IN THE NEW PATTERN OF SERVICES

3.1 A number of different elements make up the comprehensive network of services envisaged in the new pattern. It is however the building up of team-work and close relationships between professional staffs and lay groups that turns facilities into a working and comprehensive network of services.

The primary care team

3.2 The general practitioner's role both in treatment and in secondary prevention of psychological disturbance is already expanding. Although a number of agencies may be involved in bringing mental illness to notice—in particular the Employment Medical Advisory Service and in the case of young people, the school psychological service—it is to the general practitioner that the sufferer or his family are still likely to come for help. The general practitioner moreover will not always have to rely solely on his own personal knowledge of the family to help him to identify underlying psychological problems of which the patient himself is perhaps unaware. He will increasingly have the pooled knowledge of the members of the primary care team.

3.3 The health visitor and home nurse both have special responsibilities, for example to the elderly, and in the course of their domiciliary visits may detect signs of confusion or self-neglect suggesting the onset of mental illness. The health visitor through her regular links with families with young children is able both to see a child's behaviour at home among the family and hence to give early warning of a possible need for psychological help for the child and also to be alert to signs of emotional disturbance or mental illness in other members of the family. A social worker attached to a primary health care team is well placed to contribute to the identification of social and psychological problems and the assessment, diagnosis and rehabilitation of the patient; and also to act as a link with the resources the community can offer. With their combination of professional skills and first hand experience of the individual, the home and the family, the primary care team can do much to ensure early recognition and referral for specialist treatment.

3.4 With the changing pattern of services many more mentally ill people will in future be living in the community, perhaps attending hospital on an out- or day patient basis or between spells of in-patient treatment. The primary care team have an important collective contribution to make to the care of such patients, not only by playing an appropriate part in treatment, but by keeping in close touch with patients who are prone to relapse, by helping their families to understand the nature of the illness, and by alerting the specialist services if the patient's condition or the family situation shows signs of deterioration. If they are to fulfil this role it is essential that they have the advice and support of the specialist team.*

*see further paragraphs 3.7–3.9 below.

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The specialist therapeutic team

A multi-professional approach

3.5 Multi-professional team work is of the utmost importance; and this has led to the concept of the specialist therapeutic team. A specialist therapeutic team would for example include psychiatrists, nurses, social workers*, therapists involved in occupational and recreational activities, and psychologists.

3.6 The consultant psychiatrist normally has responsibility for ensuring that the needs and progress of each patient are regularly reviewed and that other members of the team are involved in these reviews. At the same time each individual member has responsibility in his own particular sphere for assessing progress and bringing to the notice of others in the team any developments which seem to call for a wider multi-professional review. This is not to say, of course, that every member of the therapeutic team will need to be involved with every patient, or indeed that every patient either needs—or would be willing to accept—a team approach to what he may feel are intensely private problems. It is however important that staff should recognise the potential value of multi-professional working and be ready and willing to adopt this approach wherever it is in the patient's best interests. The roles of the individual members of the team, in particular the consultant psychiatrist who has clinical responsibility for treatment are discussed more fully in Chapter 9. These roles often overlap: in some situations personal skills may be more important than professional background.

Relationship with primary care team

3.7 The members of the specialist team need to be readily available for advice and consultation to colleagues in other disciplines who may have patients with psychological problems. Such relationships are of course long established between consultants and general practitioners though here too there is scope for further development as manpower resources permit. The importance of psychiatric advice for patients under the care of consultants in general medical and surgical wards is becoming increasingly recognised. A physical illness may well complicate a psychiatric disorder and vice versa. This is especially so, for example, in elderly patients and alcoholics. Relationships between the disciplines concerned with physical illness and those concerned with mental illness will be strengthened by basing specialist psychiatric services in the local general hospital.

3.8 A parallel relationship to that between the psychiatrist and his medical colleagues is developing between the psychiatric nurse and her colleagues in general hospital and home nursing. The psychiatric nurse is able to provide a direct service of advice to nurses and health visitors working in the community or to nurses in other parts of the general hospital.

3.9 The specialist team should be equally willing to seek the advice of others—particularly primary care staff—in considering the overall needs of individual patients in their care, especially over arrangements for discharge from hospital.

*see further paragraph 3.27 below.

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3.10 Another important function is to promote for other professional staff, for voluntary workers, and perhaps most important, for the families of mentally ill people, formal and informal opportunities, for example discussion groups, for learning about mental illness.

Service to a district

3.11 Although their headquarters may be in a hospital—be it a mental hospital or the psychiatric unit of the general hospital—the specialist therapeutic teams should see their responsibilities in terms of a commitment to the people and services of the " district " as a whole, and not simply to the hospital. Some members of the team are likely to carry out their work directly in the patient's home. Of particular importance is the development of community psychiatric nursing services. These are of value not only to patients and their families but also to the nurses themselves, in giving those who have hitherto worked only in a hospital setting new insights into the implications of mental illness in the home.

3.12 A vital function for the therapeutic team is the provision of a 24 hour emergency service which can be provided in the patient's home when necessary. This crisis service should be planned in consultation with the primary care services and is essential if families in particular and the community in general are to be able to cope with a higher proportion of the mentally ill being cared for outside hospital. Where such a " crisis intervention " service is available it can often help to avoid admission to hospital.

3.13 On the basis of the staffing guidelines set out in Chapter 9 each health district is likely in due course to have at least 4 consultant psychiatrists sharing responsibility for the district service. Whether the district should be subdivided so that each consultant led team has ultimate responsibility for a particular geographical sector is something which should be determined locally in the light of the views of the professional staff concerned. If this approach to the organisation of the district service is adopted it should always be sufficiently flexible to allow patients and general practitioners a choice of consultant.

Social work staff

3.14 The staff of the personal social services are of fundamental importance in the new pattern. Their contribution includes work with individuals, families and groups, and residential, day care and supportive domiciliary services. The underlying objective in this respect is to help people and their families to cope with the emotional, social and environmental problems, and any residual disabilities, which may accompany mental illness or its aftermath.

The role of the social worker

3.15 Successful rehabilitation entails the deployment of a whole range of services of which the health and personal social services are only a part; housing, employment and education, and the voluntary services, can be particularly important. It is the concern of the social services department to see that all services are mobilised in helping the mentally ill and in supporting their families. The relationship between the social services and the other agencies concerned

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is thus of crucial importance; in some instances social services staff may need to undertake a liaison function in explaining the needs of mentally ill people and the nature of the help they need from the other services.

3.16 The unifying element in these activities is the professional skill of the social worker, whether deployed in fieldwork, in primary care, in residential or day care, or in hospital. The importance of these skills in the care of the mentally ill calls for some general account here of the role and responsibilities of social workers in this respect. It is the profession itself which has the main concern with assessing and developing its own role, and there is no intention of trespassing on this responsibility, but a brief statement of general principles may be of help to members of the other professions whose work brings them into close contact with social workers, and also to the wider public.

3.17 A major aim of social work in relation to those who are or have been mentally ill is to take into account all the surrounding social factors and to assess, in combination with other professionals as appropriate, whether a continuation, rearrangement or exclusion of some of these, or perhaps an introduction of new social factors, could enable a client to cope more easily with the stress of mental illness.

3.18 This entails getting to know him as an individual, trying to maintain a consistent relationship with him, and through this relationship, perhaps modifying some of his disabilities; having a working knowledge of the symptoms, treatment, course and prognosis of his illness; being aware of his particular family relationships and offering psychological and practical support to the members of his family; knowing about the various ways in which relatives are affected by the illness; discussing the situation as fully as possible with the client, his family and others who are involved in treating and helping him; and assessing whether or not it is realistic for him to live at home. If living at home is thought to be a suitable plan then the social worker has an important part in assessing under what conditions this would be possible both for the client and his family.

3.19 The social worker needs to be familiar with the whole range of support services whether these emanate directly from the primary care team, the specialist therapeutic team, the local authority social services department, or voluntary organisations, or indirectly from other services such as housing, social security, education, and employment. The social worker must not only know what is available but must apply professional skill in considering what is likely to be best for the individual client. Social work should always include him as a partner from the outset. He may well refuse to co-operate in certain important respects and, if this is so, the particular task of the social worker is to build up a relationship over a period of time which may enable him to become more willing to accept help.

3.20 One of the skills of the social worker is to recognise the likelihood of the presence of mental illness even where symptoms appear in the form of social problems and where the client has not been in touch with medical services, and to give the most appropriate help to these clients as well as to those who have been diagnosed as mentally ill. Such help may take a variety of forms—offering a friendly contact, giving practical advice, the development of an individual relationship, participation in family therapy, group work or community work. The social worker has to take into account all the limiting factors

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e.g. scarce resources, lack of co-operation, and continuing mental illness. He has to recognise that the commitment to the client may be long term and may include working with him in hospital, and in the community, sometimes alone and sometimes with other professionals. Moreover, without suppressing the client's independence the social worker has to maintain or establish varying levels of contact with key people in the client's environment. This skill is acquired with training and practical experience; though supervision and consultation are essential in order to keep abreast of new developments and to adapt to varying professional demands. For example in a specialist therapeutic team the social worker will be working as a member of the team and contributing to the whole treatment plan from the beginning; whereas the social worker in a social work area team may well be working alone with mentally ill people who have never been formerly identified as such and who are unable to accept any contact with medical services.

Organisation of social work

3.21 The internal organisation of social work services, and their relationships with the health services, are at present in a state of transition. Much attention is being given to these questions following the transfer on 1 April 1974 of hospital social workers to local authority employment, and the report of the Working Party on Social Work Support for the Health Service*. Many of the issues involved can only be resolved by the field authorities themselves and the members of the social work and other professions. The Government's concern here is to draw attention to the special needs in relation to the care of the mentally ill which require to be taken into account in the future development of services.

3.22 Following the Local Authority Social Services Act 1970 personal social services for the mentally ill, as for other clients, became the responsibility of the new local authority social services departments. This development was the subject of some criticism, and concern was expressed about what was seen as the loss of an established service with specialist skills in dealing with the problems of the mentally ill. There are, however, many positive advantages for mentally ill people in this integrated pattern of services. Many of the social needs of the mentally ill are of a general kind not arising specifically from their illness. An integrated service places at their disposal the full range of resources that the local authority and locally based voluntary services can offer. It also makes it possible for help to be part of a comprehensive pattern of social care taking into account every aspect of a mentally ill person's social circumstances; for example, the repercussions of the illness on children, or the effect of the presence in the family of another handicapped or elderly person. An individual's or a family's social problems may come to notice before an associated mental illness is recognised, and the social services department's concern with a broad range of social problems may be the means of identifying mentally ill people who are not known to the medical services. An additional advantage is that the mentally ill can have access to the local authority social service resources without having a specific label attached to them.

3.23 Nevertheless it would be foolish to pretend that unification of the social services has not brought many problems in its wake. One of the aims of unification of social services was to ensure that authorities in deploying their services would take into account a wider range of priorities. But in a developing

*HMSO 1974

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social service which is still not equal to all the other demands being made on it, there is a real danger that groups such as the mentally ill will be given a low priority compared with other groups whose needs are more overt, as well as being better understood.

3.24 There is indeed an increasing recognition that following the implementation of the 1970 Act, there has in some instances been too much dispersion of specialist skills, and that a nucleus of staff is needed with special expertise in fields such as mental illness, who can act both as a source of advice for other social workers and as a link with other specialist disciplines. It raises general questions about training which are touched on further in Chapter 9.

3.25 This should not involve any separation of social work with the mentally ill from other social work. Mental illness may or may not be a factor in a whole range of social problems, and its presence or absence is often uncertain. In these circumstances work with the mentally ill is bound to remain an integral part of most social workers' caseloads. But the presence within social services departments of staff who possess special expertise, and their ready availability to advise their colleagues, should lead to greater awareness in the social services generally of the needs of the mentally ill, and ensure that help is not given only when crisis point has been reached.

3.26 The best way of providing this special expertise will vary but there is clearly an important role for the social workers who are members of the specialist therapeutic teams. From this point of view the social worker based in the hospital can give valuable help to his colleagues in the community. Conversely, hospital-based social workers can only provide an effective contribution to the work of the therapeutic teams if they are able to call on the full resources of the social services department and of other agencies outside the hospital.

Social work support for the health service

3.27 Although the details of the relationship between specialist therapeutic teams and area social work teams will vary with local circumstances, the report of the Working Party on Social Work Support for the Health Service makes a strong recommendation that hospital based social workers should come fully within the organisation of the social services department. Depending on the number of social workers in a particular hospital, they might either work together as a separate social work team or be linked into the social work area office structure. The boundaries of health districts do not always correspond with those of social services areas and it may or may not be practicable to arrange that a particular social worker in the therapeutic team deals with patients from a particular social services area. The Working Party has emphasised the importance of continuity of care and of avoiding rigid barriers which prevent either community-based social workers from seeing clients in hospital, or those based in hospital from seeing them outside.

3.28 Similar considerations apply to the relationship between social workers in the area teams and those attached to primary care teams.

Volunteers

3.29 As well as giving practical individual benefit, voluntary help has a particular value as a spontaneous expression of the community's concern with the

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well-being of those of its citizens suffering from mental illness, and voluntary activity can itself be the means of awakening and spreading concern of this kind.

3.30 Help from volunteers is more effective if it is efficiently and sympathetically organised, and organisers of voluntary services have been appointed in a number of hospitals and by many local social services authorities. The Government hopes that this practice will spread. As well as ensuring that the volunteers are efficiently deployed, it is important that recognition and understanding is given to their motivation for helping. Volunteers wish to demonstrate their interest in and concern for the mentally ill, and will appreciate being able to learn more about the problem than is possible from contact with one or only a few patients. All will wish to be satisfied that they are making a personal contribution that is of real value, and it is important that care is taken to ensure that the help they are asked to give is such as will bring its own rewards. This will mean assessing the potential of each volunteer and looking at the job from his point of view.

3.31 It is important to recognise that volunteers are not professionally trained. They should not be seen as a means of filling gaps and deficiencies in the statutory services, but as having a distinct and complementary contribution in giving the friendship, support and help that comes from a genuine personal concern. Their lack of training may mean that they will be distressed by some of the experiences they encounter, and for this reason they may need support themselves, perhaps in the form of opportunities to discuss their experiences with other volunteers and with the benefit of advice and comment without in any sense breaking confidentiality from one of the professional staff. They must be shown how to identify situations which require professional skills to handle, they must know how to summon help, and such help must be at hand.

Voluntary organisations

3.32 Voluntary organisations have been the pioneers of many new developments in relation to the mentally ill. They draw their strength from their independence of statutory authority, and it is important not to take away the initiative of the voluntary movement and with it the enthusiasm and the freedom of action on which it relies. Statutory authorities, whether at central or local level, have many competing priorities to consider and it is important that the users of particular services, particularly those unable adequately to make their own case, should have their needs properly represented and understood. Organisations which combine access to expert knowledge with an independent stance have a unique part to play here.

Voluntary help in hospitals

3.33 Volunteers are a bridge between the hospital and the community outside, and one that is much needed particularly where hospitals are large and isolated. The greatest contribution they can make is perhaps to make individual patients feel they have a friend who has a real concern for them and is willing and able to give constructive help. They can also act as a catalyst in encouraging patients to participate in social activities, such as dances, discussion groups, clubs, film shows, drama groups and games. With the help of hospital staff they can make arrangements for excursions, visits or holidays outside the hospital for individuals or groups of patients. These activities have much

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importance as a means of encouraging patients to develop and extend their own individual interests in the world outside. Patients will, of course, gain a great deal by being involved themselves in the organisation and selection of activities.

3.34 Volunteers can help patients maintain contact with their own families and friends outside the hospital, for example, by providing transport for visitors and helping to arrange baby sitters. Some patients, particularly the elderly, may need help in reading and writing letters.

Voluntary help in the community

3.35 Mentally ill people living outside hospital have the same needs for friendship and social activity. The dangers of social isolation should not, it is true, be as great in a home or hostel whose residents mostly go out during the day, as they are in a large and remote hospital. But many residents will themselves have spent a long time in hospital and their difficulties in establishing or re-establishing social ties may be considerable. A home or hostel, particularly one that has just opened, may not have an established network of contact with the outside world, and a positive effort is needed to ensure that the home does not become inward-looking. This applies particularly to long-stay homes in which the dangers of an institutional atmosphere are perhaps greatest. Volunteers can help by befriending residents and encouraging social activities and social contacts generally. Day centres are another focal point for help of this kind. A close relationship is needed between volunteers and day and residential care staff and the planning and organisation of these services should take the voluntary contribution into account.

3.36 At March 1974 voluntary organisations were providing nearly 30 per cent of the residential homes and hostels and 15 per cent of the day centre places for the mentally ill. The proportion may fall as the expansion of local authority services envisaged takes place. But the voluntary organisations' scope for trying out new forms of help will always be needed. In particular their role in pioneering services for special groups such as alcoholics or drug addicts, and in providing shelter, support and rehabilitation for homeless single people without a settled way of life is still growing and, with the formidable difficulties local authorities face at present in finding resources for key services, may well need to grow still further though in a new partnership with the statutory authorities.

3.37 Group homes (see paragraph 4.44) are a form of direct help which many local voluntary organisations have developed with success. As well as finding and acquiring suitable housing, there is a great deal which volunteers can do to help with the practical problems. The bridge which volunteers represent between residents and the rest of the community is particularly needed in group homes where residents live without the support of permanent residential staff. Setting up these homes calls for very close co-operation between voluntary organisations and health and social services authorities. Assessing whether a particular group will be compatible and will be able to manage on their own calls for skilled professional judgment. Moreover, the help which volunteers give in running a home needs to be supplemented by various forms of social services support.

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3.38 People who are or have been mentally ill are of course living in a variety of other settings, for example, in their own flats, in family housing or in private lodgings. The danger of loneliness and isolation is likely to be greatest among people living on their own. Someone who is prepared to visit regularly and take a friendly interest can make a very great difference to the quality of their lives.

Financial support

3.39 As well as involving voluntary organisations in the planning of their services, local and health authorities have statutory powers to give them direct support both financially and by making facilities available, and the Government hopes that this means of encouraging voluntary effort will be used as fully as resources permit. Of course, the developing services for which authorities are directly responsible represent a heavy financial commitment, but a healthy level of voluntary activity is itself an important factor in the effectiveness of statutory services. The Government, for its part, will continue to give financial support to voluntary activity which has general relevance to the needs of the mentally ill.

Family care

3.40 It is important to remember that in practice those in the community most involved in the care of the mentally ill are usually their families. The implications of mental illness for the family, particularly when it is prolonged, are far-reaching. The responsibility of looking after a mentally ill relative may be very great and a family which, for example, is caring for a relative who has a long-term schizophrenic illness inevitably finds the whole pattern of its life drastically altered. Relatives of this important group of mentally ill people have now formed their own organisation which is seeking to identify the particular difficulties experienced and ways of helping the families to manage, and to bring these to the notice of statutory authorities. This development is very much welcomed by the Government. A great deal can be learnt from the experiences of families about ways in which services can be made more responsive to individual needs, and their voice needs to be listened to when policies and priorities are being determined.

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CHAPTER 4

THE DISTRICT SERVICE

4.1 This chapter describes the various units that together make up the local district network envisaged in the new pattern of services. For the sake of clarity they have to be described separately; but it is fundamental that they should be seen as inter-dependent and as together constituting an integrated whole.

Health services

The general hospital psychiatric unit

4.2 The psychiatric unit at the district general hospital is intended as the centre of specialist psychiatric treatment of mental illness for all adults, including the elderly, from its health district. Patients who need to be compulsorily detained under the provisions of the Mental Health Act should also be treated in the unit unless their clinical condition makes this clearly inappropriate. Experience suggests that most forms of difficult and disturbed behaviour can be contained by a high level of staff observation and supervision, combined with the use of locked rooms, on occasion and for limited periods, for nursing the most acutely ill. The general hospital psychiatric unit is expected to be able to deal with nearly all the small number of disturbed patients on this basis. Only when a patient is recurrently so difficult or dangerous that his treatment requires special security measures continuously and for a period of weeks rather than days should his care be regarded as beyond the resources of a local unit. The special provision required for such patients is considered in Chapter 5. Separate facilities are also required for some elderly patients who after assessment are found to be in need of longer stay hospital accommodation. These are described in paragraphs 4.13–4.17 below.

4.3 The general hospital psychiatric unit is envisaged, not simply as an in-patient department, but as a centre providing facilities for treatment on both a day and in-patient basis, and as the base from which the specialist therapeutic teams provide advice and consultation outside the hospital. The unit has two main functional components: the wards, or rather residential units, and the day hospital or day activity area. Only a very small proportion of in-patients will need to remain on the wards during the day. The great majority will be up and about and will be able to leave the ward to spend the day on a planned programme in the day hospital, returning to the residential unit at night, thus having the stimulation of a changing environment and a pattern of living which more closely resembles normal everyday life.

4.4 The great majority of in-patients will be discharged in a matter of a few weeks: the wards on which they sleep will normally have not more than 30 beds, sub-divided into single bedrooms and bedrooms with 4 or 5 beds which in their layout and design will aim to provide a friendly non-clinical atmosphere. Some patients may stay in hospital on a 5-day week basis, going home for the

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week-end. However, even with the most thoughtful design, a hospital ward has limitations as a home for patients requiring longer-term care. Those patients therefore who need specialist medical and nursing supervision for longer periods should so far as possible be treated as day patients while living either at home or in a hostel nearby. The need for long stay in-patient facilities is considered in paragraphs 4.50–4.53 below.

Day hospital

4.5 The day activity area is the hub of the unit. Rather more than half the day hospital places would be used by the in-patients, the other places being filled by patients coming to the hospital on a day basis. It should have facilities for treatment, including an ECT suite, together with consulting rooms and offices for the various professional staff and separate rooms for group and individual therapy. It should also provide a wide range of occupational and rehabilitation activities. The Design Guidance published by the Department of Health and Social Security* allows space for eight different occupational areas, which might for example be used for educational, clerical and industrial work, dressmaking, art and music, as well as a kitchen in which domestic skills can be relearnt. The unit should have its own dining room and facilities for leisure activities in the evening and at weekends.

4.6 Where the district general hospital serves a large geographical area it may be appropriate to provide an additional separate day hospital where it can meet the needs of the outlying community. A peripheral day hospital might be provided in association with a community hospital. The guideline for day places in a separate day hospital (with no in-patients attending) is about 0·3 places per 1,000 population.

4.7 Some out-patients may attend the unit for specific treatments, but as a rule out-patient facilities should be provided either at the hospital's general out-patient department, or at community hospitals or in health centres. The latter offer a particularly valuable opportunity for providing specialist services nearer to the patient's home and enabling the psychiatrist and other relevant members of the specialist therapeutic team to consider individual cases in conjunction with the general practitioner and other members of the primary care team. The latter will in turn have the stimulation and interest of involvement with the specialist therapeutic team and of being able to maintain a closer interest in their patients' progress.

Guidelines for beds and day places

4.8 The scale of provision suggested for psychiatric units in general hospitals is a minimum of 0·5 beds and 0·65 day hospital places per 1,000 total population. The ratios are of course in terms of the new pattern of care envisaged, in which this particular element is only one part of the whole network of provision. Experience so far has been limited to facilities operating in isolation, and not as a comprehensive service; and uncertainty must attach to the effect the provision of local integrated services will have on the pattern of demand for psychiatric treatment and care. On the one hand there is little doubt that local facilities once established attract more patients. Moreover psychiatric units in general hospitals receive many referrals from the medical and surgical departments of

*Hospital Building Note No. 35, December 1973, HMSO.

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the hospital. On the other hand if patients come to seek treatment earlier and if higher levels of staffing make it possible to provide a better service, it may be that some more serious episodes will be prevented. The ratios are necessarily no more than a considered assessment of the requirement. They may well need to be modified as the pattern of local facilities develops and new trends become more clearly established. Such evidence as is available so far would suggest that the day place ratio in particular may need to be raised.

Facilities for the elderly

4.9 Mental illness in old people is often too easily regarded as untreatable, but experience has shown that early intervention can be particularly effective.

Assessment

4.10 The physical uprooting of an old person is in itself a traumatic experience and may intensify existing anxieties or create new ones; assessment of mentally disturbed elderly people should, wherever possible, take place at home or in out-patient clinics. However, admission to hospital is necessary for some; and the value of an early brief admission for assessment purposes only should not be underestimated. Indeed at present the elderly form 20–25 per cent of all admissions to psychiatric hospitals and the age specific admission rate for the elderly age group is higher than for any other. In the new pattern of service admission would in most cases be in the first instance to the general hospital psychiatric unit. In some districts a psychiatrist with a special responsibility for the elderly has been appointed and there may be advantages in this arrangement, particularly in facilitating links with geriatric physicians, primary care teams and social service departments.

4.11 Many elderly patients have both physical and mental symptoms and joint assessment by a psychiatrist and a geriatric physician is desirable. Where a general hospital psychiatric unit is in being, closely related to the geriatric department, this joint assessment can take place in either department; but where a general hospital psychiatric unit has yet to be established facilities should generally be provided in a joint assessment unit in the geriatric department at the general hospital. Although in such cases clinical responsibility for the assessment unit as a whole would normally fall to the geriatric physician, the psychiatrist will need to be involved in admission arrangements and assessment should be a joint responsibility. Patients would not normally remain in the assessment unit for more than about 4 weeks, patients needing further treatment being transferred to the geriatric or psychiatric wards as appropriate. The size of such units will vary according to the local admission and treatment policy. A unit of 10–20 beds should serve for a population of about 250,000, and in some districts it has been found sufficient not to set up a special unit but simply to designate a few beds in the geriatric department of the general hospital for joint use by the geriatrician and psychiatrist. As geriatric and psychiatric departments become provided in general hospitals in close proximity to each other the need for special joint assessment beds is likely to diminish.

4.12 The extent to which in a general hospital psychiatric unit elderly patients should be treated separately or with patients of other ages will depend on individual requirements and is best left for local decision.

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Facilities for the elderly severely mentally infirm

4.13 A proportion of elderly people will, after assessment, be found to need continuing hospital care. The vast majority of these patients will in practice be those suffering from dementia, and their continuing care will not entail the wide range of diagnostic and treatment facilities of the general hospital. Their need is rather for nursing supervision by group observation, with individual nursing attention as occasion arises throughout the 24-hour period. Although most such patients who have no significant physical illness or disease are at present cared for in mental hospitals, small long stay units are now being developed in local hospitals where numbers can be kept manageable and where the interest of friends and relations and local communities can be more easily maintained. The general hospital may serve this function for the people living in its immediate vicinity.

4.14 Bed provision, which it is anticipated will increasingly be made in community hospitals as these are developed, is thought to be needed on the scale of 2·5–3·0 beds per 1,000 population aged 65 and over; this is equivalent to the number of beds at present occupied by patients suffering from dementia in mental hospitals and is thought to represent the requirement for persons needing hospital care for this condition at any one time.

4.15 Responsibility for admission would rest with the psychiatrist to whom the patients will have been referred for assessment and who will in some cases be a psychiatrist with a special interest in the psychiatry of old age. Day to day medical care may be given by local general practitioners working at the community hospital. Admission, treatment, and discharge policies will be established between the psychiatrist and the medical staff of the community hospital in the light of policies adopted for services in the district; there will also need to be close links with other consultants on the physical needs of the patients. There will normally also be a geriatric longer-stay unit sited at the community hospital which will include among its patients those suffering from dementia who have in addition some significant physical disease or illness. Here also there is a call for close co-operation between the geriatric physician and the psychiatrist.

4.16 Long-stay accommodation for the elderly severely mentally infirm could be sited close to the longer-stay geriatric wards and should, wherever possible be on the ground floor. There should be a day hospital adjoining the wards for the elderly severely mentally infirm with capacity for 2·0–3·0 day places per 1,000 population aged 65 and over. The day hospital will serve both the in-patients, many of whom are likely to benefit from a fairly active day, and patients from the local community who are able to return home at night. Detailed guidance on the design of long-stay accommodation and day hospitals for such patients is under consideration by the Department of Health and Social Security.

4.17 The nursing staff caring for the elderly severely mentally infirm may need to include both psychiatric and general nurses. With the passage of time, some patients are likely to develop physical illness which, while not always necessitating transfer to the geriatric unit, will often require general as well as psychiatric nursing care. Nursing requirements are particularly demanding and it is essential that some staff should have had both psychiatric and geriatric

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training. The remedial professions too have a considerable contribution to make to the care of patients suffering from severe mental infirmity. Physiotherapy is essential to prevent or ameliorate physical deterioration. Patients' lives should be made as interesting, enjoyable and active as possible and a wide range of occupational therapy and social activities is needed. Handicrafts, social functions, musical entertainments, bingo and simple games such as skittles have all been tried successfully. There is much scope for unqualified helpers. Services for the elderly severely mentally infirm sited at community hospitals will provide more scope for local voluntary help and for collaboration with the primary care teams—general practitioners, health visitors, home nurses and social workers—and for the involvement of patients' families and friends. Relief can be given to families caring for an elderly relative both by making day hospital care available and by occasional spells of admission to provide holiday or emergency relief.

Social services

4.18 Critics of recent trends in care have seen the present serious deficiency in the number of homes, hostels and day centres for the mentally ill as a major barrier to achieving a transfer to community care, and substantial expansion of these services, as soon as economic circumstances permit, is an essential element in the Government's strategy.

General policy

4.19 There are two distinct but related needs—for social care and for rehabilitation. The length of time for which social care is needed varies greatly. For some it is no more than a relatively short period perhaps for acclimatisation on leaving hospital, for recovery from a domestic crisis, or for a temporary relief of family stress. Others may however need shelter for a very much longer time, in some cases throughout their lives.

4.20 It is easy to underestimate both the time and the amount of help which may be needed to recover from a mental illness. If the help given is insufficient or inappropriate the whole endeavour of treatment and rehabilitation may fail. It is very important that needs should be individually assessed and that day care and residential care should be geared to meeting individual requirements. It is important also to recognise that these needs differ in nature as well as extent. Some people may be fairly self-sufficient in one respect but need a great deal of help in another; for example, someone may be able to hold down a job but may not be able temperamentally to manage life on his own. If he has no viable family ties, some form of sheltered accommodation is essential. The aim always should be to respond to individual needs rather than to pursue generalised goals which for many of the mentally ill have little relevance.

4.21 This implies a range of services that is both varied and flexible. Various forms of residential accommodation are needed to cater for different degrees of dependency and for different lengths of stay. Day centres need a variety of facilities which, within a single establishment, can be used flexibly to give effective help to each individual. Residential and day care services should be conceived not as a self-contained system but as part of a broad range of options —extending beyond the health and personal social services—for helping the

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mentally ill. This range of options should include ordinary housing as well as residential care; and open and sheltered employment as well as day care. Every possible opportunity should be taken to develop links between homes and day centres and the general life of the community. This aim may be defeated if homes and day centres are provided on the same site; the resulting complex is liable to be seen as, and indeed to become, a self-contained institution separate from the outside world. At the same time, reasonable ease of travelling between the places where people live and those where they go in the day-time is clearly important.

4.22 The development of residential, day care, and social work support services must be co-ordinated. From the patient's point of view, discharge from hospital to a community which lacks the hospital's facilities for day-time shelter and occupation may well be a change for the worse.

Estimates of need

4.23 The precise extent of the expansion of residential and day care services that is needed is not yet certain. This has been the subject of a number of research studies and in the light of these studies, guideline targets for provision were published in a circular issued in 1972 by the Department of Health and Social Security. These guidelines are regarded as provisional targets and are reproduced below (para 4.64). More experience and research are still required in this field and the Government wishes to emphasise their tentative and general character. The level of local need can only be fully determined in the context of the individual locality. Health and social services authorities should pool their knowledge so that as full a local assessment as possible can be formed. This should take account not only of the known numbers of mentally ill people but also of factors which are known to be associated with a high incidence of mental illness such as poor environmental conditions and high suicide and attempted suicide rates.

4.24 Detailed guidance on the design of homes, hostels and day centres for the mentally ill and applicable to both new and adapted premises, is being prepared by the Department of Health and Social Security.

Day care

4.25 Day care services involve a wide assortment of activities with varied goals for different individuals, and maintaining the necessary sense of purpose and direction calls for skill in management and planning. Day care services are at present perhaps the least developed of all mental health services. There is a need for pioneering work, and it is important that new experience is shared as widely as possible.

4.26 It is not easy to draw an exact line between the functions of day centres and those of day hospitals; and there is moreover an area of overlap between the role of day care and that of sheltered employment. The planning of these three services in relation to each other thus requires particular care. Day centres, like day hospitals, have a broadly therapeutic role, but their orientation is social—unlike that of the day hospital where the activity and therapy form part of a treatment programme under medical supervision. On the other hand the therapeutic accent, and the mixture of social and work-directed activities,

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distinguish day centres from sheltered employment services—even though rehabilitation for employment is an important part of a day centre's function. Health, housing, education and employment services all have a contribution to make, as do the voluntary organisations which indeed may well provide a substantial part of the services.

4.27 Some local authorities have been successful with mixed services in which mentally ill people share facilities with one or more of the other groups, but there is not enough experience yet to show whether this is a satisfactory long-term arrangement. There is room for further experiments with such an approach provided sufficient flexibility is retained (*e.g.* in the design of centres) to permit the introduction of a degree of separation between different groups if experience proves it necessary.

Aims of day care

4.28 On one level the goal of day care is to meet clients' immediate needs for shelter, occupation, and social activity. In so doing the centre may also serve to relieve the strain on the client's family of looking after him during the day, or conversely to give the client himself a few hours away from the family. In some cases this may be what makes it possible for the client to continue living at home. While for some the help which the centre gives will be needed for a long time, for others it could be a relatively short stepping stone towards eventual independence. This is not to imply the existence of two clearly differentiated groups. Only a tentative judgment may initially be possible about an individual's capacity for progress and the length of time for which he will need support. A more definite opinion can only be formed over time on the basis of regular reassessment. In any case people can be given an increasing degree of self reliance even though they need a measure of long term support, and the difference in individual goals is more one of degree than of kind. In the overriding aim of improving the quality of life, the long term support which some people need is just as important as the help given to others to achieve complete independence.

4.29 Of the main elements involved in day care, the first is help with difficulties in forming or maintaining personal relationships. A second involves help with problems of adjusting or re-adjusting to the demands of work. A third consists of encouraging the realisation of the individual's potential capacity for a fuller and more rewarding contribution to the life and work of the general community, and for a deeper enjoyment of his own life. It is important that no one element, for example work processes, should be allowed to dominate the whole programme. Cultural and educational activities—for example the study of art, music, drama or literature—have a valuable part to play. Some may need to learn about cooking or housekeeping. The general pattern of work activities will need to reflect the social profile of the district, but it is important to include white collar work and such office work as typing, duplicating and printing, as well as work of a more industrial character.

Organisation of day centres

4.30 More important than the exact mix of activities is the way they are planned and organised. Those attending the centre should be encouraged to take part in this process; their involvement in shaping the programme should

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not only help to make it more relevant but should also be a means of developing self-confidence and self-reliance. In keeping with this aim, the centre should not be allowed to become a closed community which seeks to meet all its users' needs; rather it should be seen as a focal point from which they may move out to use general public services. Libraries and the adult education services are examples.

4.31 The key to effective use lies in individual assessment. This involves looking at each individual's present level of functioning and drawing up a programme of activities needed to help him reach better adjustment. Such an assessment will only be valid if the staff of the day centre bring into consultation those who have the relevant professional knowledge about the client himself. Assessment is a continuing process and the programme of activities should be reviewed periodically in the light of the client's performance and changing needs. The programme should, of course, take as much account as possible of his own expressed wishes. Consideration will need to be given to what is to happen when he stops attending the day centre; and arrangements will need to be made to ensure that those who can move into paid work are encouraged to do so and are identified at the most appropriate stage for assistance through the assessment, rehabilitation, training and resettlement facilities of the Employment Service Agency and Training Services Agency. The Disablement Resettlement Officer will have a significant role to play at this stage.

4.32 Day centres call for staff having their own considerable range of skills, supplemented by advice from other social services staff and from, for example, psychiatrists, psychologists, nurses and teachers as necessary.

Day centre planning guideline

4.33 The guideline planning figure for day centre places for the mentally ill is a ratio of some 0·6 places to 1,000 population.

Location of day centres

4.34 The main consideration in deciding the location of day centres is probably the need for an accessible service. Good public transport facilities are important, and where these are inadequate the social services department may need to make some transport arrangements of its own. The question of siting is obviously related to that of size, since a heavy concentration of day places in a single centre will make it less accessible for those who live further away. Equally though, it is undesirable for day centres to be too small; with fewer than, say, 40 places it will be very difficult to provide a full range of services. Exceptionally, in densely populated areas, a centre might have as many as 150 places.

Social clubs

4.35 Social clubs are a valuable supplement to day care, particularly for people who are busy during the day but lack opportunities for social activity and friendship. Running and organising such clubs may be a particularly suitable activity for voluntary organisations, especially where local authorities are ready to help with finance and general guidance. Some people who have been mentally ill may benefit from the opportunity to help others by themselves participating in the running of a club. Mutual support of this kind may be

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of particular value for groups such as agoraphobics where contact can be made by correspondence or telephone between phobics who find it difficult to make their way to facilities at a distance from their home.

Residential care

4.36 Residential services have to meet a variety of needs. But whereas a day centre can be relatively large and so can encompass many different activities under one roof, homes and hostels have to be reasonably small if an institutional atmosphere is to be avoided. In order to provide effectively for a range of individual needs, homes and hostels will need to offer a number of alternative patterns of living.

4.37 The Department of Health and Social Security's planning guidelines for hostels and homes have differentiated between short-term and long-term needs. There is a risk that such distinctions may be too rigidly applied. In particular it is unrealistic to make decisions about the duration of stay required when someone first enters the home or hostel, and the choice for an individual client of a particular type of accommodation should not be determined solely by this. The deciding factor should be the extent to which the alternatives available meet the individual's needs at the time and his own preferences.

4.38 The broad choice should be between hostels providing a relatively intensive programme of rehabilitation; staffed homes; small group homes and lodging schemes. For some mentally ill people the underlying problem will be one simply of housing. Close co-operation is needed between social services and housing authorities to ensure that such problems are recognised and tackled in the most appropriate way. This aspect is discussed further in Chapter 6. One of the aims of residential care is to help people to achieve a reasonably stable pattern of life and to develop the capacity to cope with the various pressures of daily living. At the same time it must be recognised that some may never be able to face these pressures alone, and will require a degree of more permanent support.

4.39 Whether or not people ultimately become able to face life quite independently, they can all be helped in some degree to manage their own lives. To achieve this homes and hostels must be outward looking. Residents should as a general rule be encouraged to spend the day time elsewhere, in sheltered employment, in an ordinary job, or attending a day centre or day hospital. Siting and design can also do much to help. It is important that homes and hostels should be located in residential areas where they fit in naturally and unobtrusively with other housing. Some kinds of accommodation can, for example, be conveniently planned as part of local authority housing development. It is also important that facilities should be shared by both sexes. The quality of life can gain much from this, and segregation serves no useful purpose.

Hostels

4.40 Present thinking suggests that hostels for short-term care and rehabilitation will, numerically, be a relatively small element in a comprehensive service. They are nevertheless a very important element. The suggested guideline level of provision is 8–10 places per 200,000 population in an area of " average need " and 10–12 places in an area of " high need ". The function of hostels is closely linked with that of the specialist psychiatric services. Their

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basic purpose is to provide intensive care and rehabilitation on a relatively short-term basis. This may represent a period of acclimatisation during which someone who has left hospital can gradually get used to the pressures of life outside, or sometimes the hostel may provide a temporary but much needed retreat from these same pressures for a person who is not so severely ill as to require admission to hospital. There should thus be no set pattern which all residents have to follow; the approach to rehabilitation can only be decided in the light of each individual's needs and problems. This is a highly skilled judgment and it is important that the staff of the hostels should be carefully selected and that support should be readily available from their colleagues in the social services and health professions.

4.41 Participation by residents in the running of the hostel is often a valuable part of rehabilitation. The element of freedom of choice is important, and should be reflected in the design and organisation of hostels. Residents should have their own rooms and be able to get reasonable privacy when they want it. 10 or at the most 15 is probably the maximum number of residents which is compatible with an environment of this kind.

Staffed homes

4.42 Staffed homes are a form of accommodation offering continuing support, and in which, while rehabilitation remains an important element, the emphasis is on providing a home. Many of the people needing this form of help are those who have spent a long time in hospital and who, although they have left behind the acute stage of their illness, have lost their roots in the community and would find it difficult to form new ones. Another group are those who have depended for their support on relatives who have now grown old or have died. A home in which people are likely to stay for a long time must be designed to fit into and form part of the wider community, and the total number of residents should not be more than about 25. A domestic and informal atmosphere is important. The design should allow for the formation of small groups within the home, but with sufficient flexibility to allow for individual choice.

Unstaffed accommodation

4.43 There are various forms of unstaffed accommodation which can be used to meet both long-term and short-term needs for shelter, but without the same degree of support as in staffed homes. There is scope here for experiment with new solutions, depending on what the locality has to offer. Unstaffed accommodation may in some instances be planned in conjunction with staffed homes; for example a number of bed-sitters may be provided in the same locality as the staffed home, where people can live independently but with access when they need it to help from the staff of the home.

4.44 An approach which has been tried with some success is the group home. These homes have been shown to be suitable for people who can manage more independently but who—perhaps because their own family ties have been lost —need the mutual support of living together in a small compatible group. Ordinary flats or houses are suitable for this purpose. The success of a group home depends largely on the selection of a compatible group of people. To enable the domestic side to run smoothly it will usually be necessary to arrange

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at the outset for one of the residents to act as housekeeper and this means selecting as a resident someone who has both the aptitude and inclination for this role. Social work support is essential, particularly during the early weeks or months when the members of the group are settling down to life together and need advice on financial, catering and other domestic matters. It is a considerable help for the social services department to underwrite the rent so that, for example, the departure of one of the residents does not leave the group in an impossible financial situation until the vacant place is filled.

4.45 Group homes are a relatively economical and straightforward form of accommodation, and represent a tangible form of help which can often be given by voluntary organisations. It is important to realise, however, that group homes are not by themselves a sufficient alternative to hospital care, and they should not be established without arranging adequate opportunities for employment or day care for those residents who need it.

Supervised lodgings

4.46 Supervised lodging schemes, which a few local authorities have developed quite extensively, are a rather different form of long term support. There are two main patterns—the lodger may either live more or less independently in a sub-let room, or as part of a family. In either situation the landlady represents the first line of support, and the selection of landladies, and the choice of lodgers, require a good deal of care. Social work support and advice should be available to the landlady no less than to her lodger. There may be scope for extending this arrangement to families where there is a mentally ill parent with dependent children.

Guideline for staffed homes and other long stay accommodation

4.47 Guidelines for the various forms of longer stay accommodation suggest for an area of " average need " a minimum of 30 places for a population of 200,000. At least 10 of these should be in staffed homes and at least 15 in the other types of accommodation. For an area of " higher need ", the overall minimum suggested is 48 places, with at least 16 in staffed homes and at least 24 in other accommodation.

Care for the elderly mentally infirm

4.48 Paragraphs 4.13–4.17 discuss hospital provision for elderly people who are severely mentally infirm. There are also however many elderly people suffering from dementia in a form which is not sufficiently severe to warrant admission to hospital. For the most part they are cared for in their own homes by their families with the support of primary health care and social services but some are cared for in residential homes. Many local authorities make places available for them in old people's homes, sometimes by way of a separate wing or floor; some provide homes especially for elderly mentally infirm residents. The Department of Health and Social Security is examining the advantages and disadvantages of the various methods adopted by local authorities and may issue guidance on the subject in due course.

4.49 The point at which mental infirmity is severe enough to be beyond the scope of residential care is not easily discernible: indeed, the condition of

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an old person suffering from dementia may vary from day to day. Nonetheless there is a need to clarify the relative responsibilities of the health and social service authorities in respect of the care of the elderly mentally infirm so as to secure the most effective deployment of the resources available; and the Department of Health and Social Security intends to mount a research project to this end. Other matters under consideration by the Department are the development of joint medical and social work assessment procedures to facilitate the most appropriate placement of elderly mentally infirm people no longer able to be cared for in their own homes and to facilitate subsequent transfers between residential homes and hospital where changes in their condition make this appropriate. More generally, in the light of the increasing age and frailty of residents of old people's homes consideration is being given to the need for further guidance on arrangements for providing medical and nursing care.

The long term care of the chronic mentally ill

4.50 Earlier paragraphs have already referred to the importance of those —albeit a small proportion of all who suffer from psychiatric disorders—who are likely to need a high level of support and care, including residential care for prolonged, indeed in some cases indefinite, periods. How will their needs be met within the new pattern of service?

The " old " long-stay patients

4.51 At the time of the Census of mental hospitals in 1971 there were 104,638 occupied beds in mental illness hospitals in England (representing 2·27 per 1,000 population), of which 75,923 (1·65 per 1,000) were occupied by patients who had been in hospital for more than 1 year. Of this group 57 per cent (0·94 per 1,000) had been in hospital more than 10 years; 39 per cent (0·65 per 1,000) more than 20 years. The treatment which these long-stay patients received when first admitted—indeed the severity of illness which necessitated their admission—will have varied very considerably according to the time they were admitted. Many of them, were they to suffer the same illness now might not require admission at all but would be treated as out-patients or day patients, or if they were to be admitted, might stay weeks or months rather than years. Many of them are still in hospital not because they need specialist hospital services but because they either need other forms of shelter and support which are at present not available outside hospital, or have become so accustomed to hospital life—in some cases so institutionalised—that it would be inhuman to discharge them from the hospital that has in effect become their home. It is these patients who are often referred to as the " old " (as distinct from the " new ") long-stay patients. They are not easy to define in numerical terms. They can be defined only perhaps by saying that they represent those patients whose need for long-stay hospital care is the result of past—and less advanced—patterns of treatment. There is little doubt that virtually all those patients who have been in hospital 20 years or more would fall into this category. So too would a substantial number of those who have been in hospital more than 10 years, many of whom were admitted between 1951 and 1961, the decade when new treatments were just being developed. Even those admitted 5–10 years prior to the census will not have had the opportunities which exist now for day hospital treatment and will have been treated in hospitals with far lower staffing standards than those of today.

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The " new " long-stay patients

4.52 Nevertheless, it is clear that despite advances in treatment and staffing there are still significant numbers who become long-stay hospital patients. At the time of the Census 21,540 (0·47 per 1,000 population) had been in hospital between 1 and 5 years. By 1972, this group had declined by about 1,000 patients to give a rate of 0·44. It is also clear that to a considerable extent their numbers are the result of a lack of other more suitable facilities rather than a need for hospital in-patient care as such. The Department of Health and Social Security has recently sponsored a research study carried out by Dr. Mann and Mrs. Cree of the characteristics of this " new " long-stay population. The study deliberately concentrated on new long-stay patients other than those suffering from dementia, since separate provision for these is envisaged in the new pattern of service (see paragraphs 4.13–4.17 and 4.48–4.49 above). The study examined a sample of patients aged under 65 who had been in hospital more than 1 and less than 3 years, with the aim of establishing whether they were still in hospital because they needed 24 hour medical and nursing supervision or whether their needs would have been more appropriately met by other kinds of residential facility had these been available. (A preliminary account of the study is given in " Providing a Comprehensive District Psychiatric Service for the Adult Mentally Ill ")*. It estimated that about one-third of these newly arising long-stay patients needed 24 hour medical and nursing supervision—and that the remainder, except for small numbers in special groups, required varying degrees of sheltered environment in the community.

4.53 The third who were felt to need 24 hour nursing care with medical oversight, were drawn predominantly from those suffering from chronic schizophrenia. Such patients are particularly prone to be slow and withdrawn and liable to neglect themselves. While a general hospital psychiatric unit could probably provide a satisfactory living environment for patients staying for periods up to a year or thereabouts, it would not be a suitable " home " for the small number of chronic patients who might need hospital residential care for longer, perhaps indefinite, periods. On the basis of this study, Professor Wing has estimated that the number of hospital places required for " new " long-stay patients aged under 65 would be about 0·17 per 1,000 or 30–35 in an average health district. This would of course only meet the needs of the newly arising long-stay patients in a local service. It is important to appreciate that all the guideline figures given in this Chapter are in addition to the beds—gradually declining in numbers—which will still be required for many years to meet the needs of the " old " long-stay patients, referred to in paragraph 4.51 above, who are already in the mental illness hospitals.

Hospital hostels

4.54 One approach to meeting the needs for hospital residential care for " new " long-stay patients, which it is hoped to test in a research project at Southampton, is a form of hospital hostel. On present thinking such hostels are likely to be fairly large houses reasonably close to the general hospital psychiatric unit, with the patients being cared for in a domestic atmosphere but with night nursing supervision. By day they would either attend a day hospital

*Department of Health and Social Security Reports on Health and Social Subjects No. 8 HMSO.

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or a local authority day centre or perhaps go out to sheltered work. Such a unit would be aimed not simply at providing long-term psychiatric care as such, but rather at a social environment with a slower pace and tempo more appropriate to their disability.

Brain damage

4.55 Mention should also be made, in the context of long-term care, of patients with head injuries some of whom are at present nursed in the mental illness hospitals. Multiple problems are presented by people who suffer acute brain damage, whether traumatic or due to vascular accident and at the present time they are dealt with in a variety of different ways. Some people develop behaviour disorders after brain damage and need referral for psychiatric care; depending on the circumstances this may need to be given either as an in-patient or as a day or out-patient. Others, depending on the degree of residual deficit, may in time need placement with the younger disabled or the older demented. But one of the aspects of the care of this type of patient, particularly with the younger patient who has suffered trauma, is that slow improvement over a very long term can sometimes be expected. This makes it essential for such patients to be regularly reassessed and their treatment régime altered as necessary.

Present uncertainties and future planning

4.56 It is clear that unless and until there are further major breakthroughs in the treatment of the more disabling psychiatric conditions, some chronic mental illness will continue. There is an urgent need for more research into the overall size of the problem: the study described above looked at patients already in hospital, but little is known about the chronically disabled in the community whose needs are unmet or are being met only at the price of near intolerable strains on their families, or who are perhaps living with elderly relatives who will be unable to cope with them for much longer. We also need to know more about the needs of the group in terms of services: how many, given the comprehensive network of local services envisaged for the future, will require residential care, as distinct from day hospital or day care facilities. How many of those requiring residential care will need hospital residential care and how many accommodation in a sheltered environment outside hospital. There is some hope that as services improve and are able to offer earlier intervention and more intensive support the numbers of those needing long term *residential* care may ultimately decline. Until local comprehensive services are in being and we are able to monitor their effectiveness planning must nevertheless proceed on the basis that there will continue to be a number of mentally ill people—though smaller than hitherto—who will need long term residential care, and that some of this will need to be in a health service setting.

Care of people without a home or settled way of life

4.57 The mode of life of those men and women who have no settled home and have drifted into the way of the single homeless—using lodging houses, reception centres and derelict houses for shelter and sleeping rough from time to time—is not in itself a reason for discussing them in a Command Paper on services for the mentally ill, still less for referring them to the psychiatric services. But a number of different studies have suggested that the prevalence

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of psychiatric and personality disorders, as also of alcoholism or drug misuse is especially high among such people, both among the drifting youngsters whose problems are discussed in Chapter 7, and those whose way of life approximates to that of the traditional vagrant.

4.58 In a recent survey at the Camberwell Reception Centre, only 13 per cent of the men who had received in-patient psychiatric treatment were homeless at the time of their first admission to hospital. This would appear to lend support to the theory that rather than homelessness having been a precipitating factor in the illness the long term effects of the men's psychiatric condition and the inadequacy or unacceptability of the services provided to help them may have led to their becoming and remaining homeless. It should be emphasised that though the number of men in this group suffering from some degree of psychiatric disorder or its after effects may be large, the number in immediate need of hospital treatment is much smaller. There may also be a group who are unable, or highly unlikely, to benefit from further treatment, but liable without some continuing support to create problems for themselves and other people.

4.59 The problem is that men and women who are homeless are particularly difficult to help. Hospital staff and others in the mainstream of such services often find it difficult to communicate with and help people who seem alienated and unco-operative and whose response to the help they give may be poor. Their lack of an address and settled way of life may make it difficult for them to find and go to a general practitioner, keep appointments or make use of health services: some discharge themselves from hospital without completing their treatment, and others who do complete treatment are sometimes discharged without proper after-care arrangements and with nowhere to go because of the difficulty of finding the right sort of supportive accommodation. The new patterns of psychiatric care now being developed may increase the difficulties of this group because of their emphasis on active treatment, and the fact that many of the day and residential services provided for the after-care of the mentally ill are not well geared to helping people without a settled way of life and may not either attract or accept them.

4.60 These special difficulties of homeless people need to be recognised by workers in the health and social services everywhere. In areas where there are large lodging houses or reception centres special thought needs to be given to the psychiatric services required. Local authority or voluntary staff working with the homeless can be helped by the psychiatric services to accept and cope with the residual effects of mental illness in some of their residents. In general it is thought that special psychiatric services are not required for those with an unsettled way of life: when they need treatment they need simply—like everyone else—to be treated effectively, promptly and with understanding. Some hospitals serving the central areas of cities where homeless, rootless people congregate have particular experience in caring for them, but more needs to be known about how the psychiatric services could be of help. An experiment is to be mounted at Bexley Hospital which should throw some light on this.

4.61 After-care arrangements need particular attention. It is essential that plans are made well before the time of discharge for men and women whose history shows they are likely to need especially well-chosen arrangements for after-care if they are not to slip into, or back to a drifting way of life. The

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problems of homeless men who have been mentally ill are overlaid and exacerbated by the general shortage of cheap accommodation for single people, and how much the need may be for special residential services to provide this type of man with care and support may not be clearly seen until the supply and demand for single person accommodation is more nearly in balance. Included in the Housing Act 1974 is the provision that, for the first time, local authority expenditure on hostels will be included in the housing revenue account. The Act also provides for a considerable increase in the help available to housing associations by means of housing association grants designed to cover the whole spectrum of housing need including self-contained and hostel accommodation where the primary purpose is to provide housing. In Circular 37/72 the Department of Health and Social Security invited local authorities to set up experimental projects to meet the needs of homeless single people requiring care and support in a residential environment. Some homeless men tend to be suspicious of a structured mode of living, or anything in the nature of residential "care": they will seek out hostels or lodging houses offering only food and shelter. But others will accept help with their problems if it is offered in ways which take account of their eccentricities and the style of life they have adopted. Experiments are on the way in some areas to explore the possibilities of special day and residential services in the community. A number of voluntary experimental services emphasising the social rather than the physical environment have had some success in attracting and helping men who shun other types of help.

4.62 Social workers need to develop skills in working with men and women who are doubtful about accepting help: their confidence may most easily be gained in an unstructured environment—perhaps a day centre—where relationships can be built up and assessment take place in an unhurried and non-threatening environment. Some men easily become institutionalised, whether in hospital, prison or a residential setting, but experience suggests that where they are able to exercise choice about where they are to live and are involved in the day-to-day running of their own lives and the management of the hostels or day centres they use, there is more chance of their leading a more settled life with fewer calls on the psychiatric and social services.

Regional and sub-regional facilities

4.63 The table in paragraph 4.64 summarises the various elements described in this Chapter which together form a net work of district services to be achieved as economic resources allow. Facilities are required in addition for particular groups of patients whose numbers are not large enough to warrant services for them in every district. These additional facilities, namely, regional security units and facilities for mentally disturbed children and adolescents, are described in Chapters 5 and 7 respectively. They are an essential complement to the local district services and should be seen as an integral part of the mental health service.

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Summary of guidelines for services at district level

4.64 *Rates per* 100,000 *population*

	Facility	Beds	Day places
Hospital services	District general hospital psychiatric unit ...	50	65
	Accommodation for the elderly severely mentally infirm	30–40	25–40
	Units for the " new " long stay	†	
Local authority services	Hostels	4–6	
	Long stay accommodation	15–24	
	Day centres		60

†Still to be determined: see paragraph 4.56.

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CHAPTER 5

SECURITY

Treatment in conditions of security

5.1 Patients should be treated with the minimum degree of security and supervision commensurate with their condition at any particular point in time. Every effort should be made to ensure that no patient is subjected to unnecessary restrictions on his freedom. Some patients unfortunately are, at some stages of their illness, so continuously difficult or unpredictably violent that there is a need for them to be closely supervised and for their movements to be under strict surveillance. In these cases, in order to protect both the community and the patient himself it may be necessary to impose greater restrictions than local district services can provide; in these cases a placement in a regional security unit or in a special hospital may be necessary. Careful consideration must be given to each individual case before a place in either of these types of secure provision is made especially since both are likely to be remote from the patient's home and family thus making rehabilitation more difficult and because of the inevitable stigma which still attaches to treatment in conditions of security. Careful consideration is of course required when patients are being transferred from a more to a less secure environment, but it is important that all concerned in the mental health services should be receptive to transfers of this kind and should do their utmost to provide the after-care and support which is perhaps needed in these cases even more than in others. Only if there is sufficient confidence between the different parts of the service as a whole can there be appropriate movements in and out of these types of provision, and only then can a full and flexible service be provided in order to deal with the needs of patients as they vary over time. It is important that there should be good co-operation between the local services and these secure services. The aim should be to arrive at a situation where no patient is in a regional security unit or special hospital whose condition does not require treatment in conditions of that degree of security; in other words such placements should only be made where there are positive reasons for doing so.

Regional security units

5.2 Regional security units are intended for patients who are continuously behaviourally disturbed or who are persistently violent or considered a danger to the public, albeit not an immediate one. The units will provide physical security but will not be expected to deal with the very persistent and determined absconder or patients for whom release attempts might be made. Special hospitals will continue to deal with the most dangerous and violent patients and those who would, if they were to abscond, present an immediate threat to the public. The special hospitals aim to provide sufficient physical security to prevent a determined absconder from leaving the hospital although they are not expected to guard against a determined outside attempt to release a patient.

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5.3 Hospital authorities were recommended in 1961 to provide for patients needing security either in regional units or in provision in each hospital. Most Regional Hospital Boards opted for the latter course but there were increasing difficulties in the latter 1960s as more and more hospitals became entirely open. A working party report has recently recommended that regional security units should be provided in all Regions, and the Department of Health and Social Security has commended this to health authorities. The report also made recommendations about the ways in which such units should be organised and operated. The provision of regional security units is also recommended in the report of the Committee on Mentally Abnormal Offenders. The training needs of the nursing staff in these units are being considered by the Joint Board of Clinical Nursing Studies and field authorities will be advised of developments in due course.

Secure provision for adolescents

5.4 The question of secure provision for adolescents is a difficult one. Adolescent psychiatric units can provide security of the kind which comes from close observation and a high level of staffing, and regional psychiatric units may be expected to provide a degree of security beyond that; and there is a very small number of adolescents whose mental condition results in dangerous or violent behaviour to an extent which requires the facilities of a special hospital. None of these is, however, necessarily the right place for adolescents whose aggressive, anti-authority, anti-social and uncontrolled behaviour is not significantly related to mental disturbance. The concept of the Youth Treatment Centre providing a combination of long-term care, control and treatment, security and education for those young people exhibiting difficult behaviour who are neither appropriate for community homes nor for psychiatric units is being developed at the St. Charles Centre, Brentwood; but there has not as yet been sufficient time to evaluate it. In fact, much has still to be learned about the most suitable form of care for these disturbed and socially disruptive young people.

Special hospitals

5.5 The special hospitals provide accommodation for patients detained for treatment whose dangerous, violent or criminal propensities mean that their treatment must be carried out in conditions of special security. The three existing special hospitals which already house some 2,300 patients (of whom 1,570 suffer from mental illness or psychopathic disorder) are under serious pressure. Moreover the physical conditions at Broadmoor are most unsatisfactory. The opening of a small advance unit of the planned fourth special hospital, named Park Lane, has eased the position a little, but Broadmoor remains overcrowded. The first stage of Park Lane Hospital is in an advanced stage of planning. The transfer into it of patients from Broadmoor will make it possible to start rebuilding ward accommodation at Broadmoor.

5.6 Broadmoor will then take fewer patients than at present so that altogether there will be about 100 additional places. We shall need to reappraise the national requirements for accommodation for patients requiring this high degree of security in the light of experience of operating the regional security

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units and of the recommendations of the Committee on Mentally Abnormal Offenders.

Forensic psychiatric services

5.7 In recent years there has been a welcome development of specialised forensic psychiatric services, though somewhat sporadic and uneven. Most forensic psychiatry is still carried out either in prisons and special hospitals, or by consultants who have major commitments in other fields. The need is for each region to develop a forensic psychiatric service in conjunction with the Home Office facilities and the regional security unit. In regions where no accessible Home Office facilities exist consultants will need to be appointed wholly within the NHS. A forensic service includes facilities to cope with the growing demand for assessment (particularly court referrals) and for treatment and after-care.

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CHAPTER 6

HOUSING AND EMPLOYMENT

Housing needs

6.1 Some of those who leave psychiatric hospital after in-patient treatment need a period of residential care involving special support and rehabilitation. Ways of providing such residential care are described in Chapter 4. But many others who leave hospital are ready to return to an ordinary home immediately, needing no more than minimal support from social services. For most people there is no problem about this; but there are certain groups for whom it presents serious difficulties. Where for example a mother's illness has in part been precipitated by the stresses arising from the housing in which she was living, a return to the situation which proved too much for her before may prejudice her chance of a full recovery or even cause a recurrence of her illness. For single people who are admitted as in-patients, there is a danger that when they leave hospital their previous accommodation will not be available and, while social services staff will endeavour to prevent this, they may not always succeed. People who, before admission, were used to a shifting life of lodging-houses and reception centres need a chance to live in a more stable and secure environment if they are to maintain their recovery. Some former patients, though not needing professional care, need the companionship or support which comes from sharing a home with others with similar problems or living in lodgings with a welcoming and understanding landlady. Finally, there are the many patients in psychiatric hospitals who have been there so long that they have no homes to return to though they would be able to live a largely independent life in the community if suitable accommodation could be found for them.

6.2 In all these examples what is required is essentially ordinary housing rather than any special form of residential accommodation; and it is right to look to local housing authorities, working together with the local authority social services departments, to find ways of solving these problems. It would however be wrong to think in terms of a rigid dividing line between the residential services described in Chapter 4 and the accommodation made available by housing authorities. There will be areas of overlap between the two. For example a group home may be in a flat or house rented by the social services department from the housing department—or, and this is the procedure which should be followed wherever possible—the social services department will merely supervise the overall management including rent payment and provide any necessary social work support. Ideally, the various forms of accommodation described here and in Chapter 4 should be seen by local housing and social services authorities as providing between them a range of accommodation, from the purpose-built staffed hostel to the ordinary council house with only occasional social work support.

6.3 In the administration of their stock of housing and in allocating tenancies, housing authorities give special consideration to people whose health is being damaged by the conditions in which they are living. In this context mental illness is one factor which may warrant priority, either in the allocation of a

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council tenancy, or in obtaining help from a housing association with a special interest in such problems. Security of tenure is of particular importance to those suffering or recovering from mental illness, and should be borne in mind by housing agencies; it may tip the balance in favour of a council tenancy.

6.4 The housing problems a single person recovering from mental illness may face in returning to the community can be as great, indeed sometimes greater, than those of a patient with a family. Housing authorities have traditionally given priority to the needs of families, and single people have largely been expected to find their own accommodation. Increasingly, however, the special housing needs of single persons are being recognised by local authorities, and the Department of the Environment has itself given attention to ways in which these needs can be met. A variety of forms of accommodation can be provided, for example clusters of small flats of the kind described in the Department of the Environment's Design Bulletin 29 " Housing Single People ". Under the Housing Act 1974 local authorities and housing associations are able to receive for hostel accommodation the same sort of housing grants and subsidies as are available for other forms of housing. It is hoped the new arrangements will encourage provision of hostels for, among others, people who need limited support. The greater security of tenure given under the Rent Act 1974 for furnished tenants will also help many vulnerable people who live in furnished accommodation.

6.5 As local authorities and housing associations make more impact on the housing problems of single people, particularly in the central areas of large cities, ways will more readily be found by housing and social services authorities of solving the housing problems of people who have been mentally ill. Housing aid centres, whether run by local authorities or voluntary bodies, may be able to help find single people somewhere to live in privately rented accommodation. Housing associations, particularly those established to help people who are mentally ill, and other voluntary bodies may also be able to help, and housing authorities may be able to make mortgage facilities available to housing associations planning a housing scheme with someone to look after the tenants. Some of the suggestions made in the Joint Circular from the Department of the Environment and the Department of Health and Social Security on Homelessness (DOE Circular 18/74) are also relevant; for example, the need to remove the disincentive to council house tenants who wish to have a lodger.

6.6 The housing needs of patients who have been in mental illness hospitals for many years but no longer require continuing medical and nursing care should not be overlooked. Obviously the rate at which such patients can return to the community will be constrained by the community's capacity to meet their need for both housing and social support, but there should be an underlying recognition that hospital is not a satisfactory alternative to home. In cases where people are in hospital remote from their former home or relatives, the planning of a move from hospital to home will normally be for the housing and social services authorities in whose area the person's home was before being in hospital. In some cases, patients in hospital may no longer have contact with the place they once came from, and will have developed a number of links in the area of the hospital. They may more easily be able to make a home in the neighbourhood, and local authorities who interpret their responsibilities flexibly may be able to make this possible.

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Employment needs

6.7 Mental illness and its aftermath all too often involve a tragic waste of human potential. Part of the challenge is to minimise this by helping each individual to reach a level of employment commensurate with his potential. This in no way implies a cynical view of our responsibilities to the mentally ill. The individual frustration and unhappiness of someone who sees his abilities going to waste may be no less real than the loss it represents to society.

6.8 Mental illness tends to affect people's capacity for work in two ways—impaired functioning and changes in work attitude. Impairment of functioning, for example difficulty in tolerating stress or a high level of responsibility, cannot always be overcome and some long-term reduction of capacity may have to be accepted. If so, an important target of rehabilitation will be the development of this reduced capacity; this may involve, for example, training for some less demanding form of work. Changes in attitude to work on the other hand, are more amenable to improvement through a carefully planned programme of treatment and rehabilitation. Acquiring or regaining the ability to work effectively is often a necessary part of recovery from mental illness, and if a satisfactory resolution of work problems is not achieved the likelihood of relapse is increased.

Range of services

6.9 Some health and social services activities, for example hospital industrial therapy units and local authority day centres, are directly relevant to employment needs. There is however a limit to what these services in their present form can do. Their concern, by and large, is necessarily with problems specifically associated with mental illness. Moreover, the level of expertise which health and social services staff can develop on the specialised teaching of employment skills or basic work habits is inevitably limited by their other preoccupations. The Government's view is that specialised facilities exclusively for the mentally ill should be used only to the extent that they are justified by the special character of their needs. Help with the general employment needs and problems of disabled people is provided mainly by the wide range of resettlement services under the aegis of the Department of Employment and the Manpower Services Commission, and the Government is anxious that these services should be used as fully as possible by all people who can benefit from them, including those who are recovering from mental illness. These services include Employment Rehabilitation Centres, training at Skill Centres and elsewhere, sheltered employment and the Disablement Resettlement Service, with its function of placing people in the most suitable form of open or sheltered employment.

6.10 The employment and training services described in paragraph 6.9, and the operation of the quota scheme for disabled people, have been comprehensively reviewed over the last two or three years with the object of making them better suited to meet the needs of disabled people. In carrying out this review it has been fully recognised that people who are or who have been mentally ill already constitute a substantial group of users; and that this group is likely to expand in the future. The review has been conducted in consultation with the Secretary of State for Employment's National Advisory Council on Employment of Disabled People on the basis of a number of consultative

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documents or discussion papers dealing with different aspects of the services. Agreement has now been reached on the broad lines on which the employment and training services provided for disabled people by the Manpower Services Commission should be developed; and details of these developments have been set out in the plans published by the Commission's Employment Service Agency and Training Services Agency in 1974. The main developments are summarised in the following paragraphs. Decisions about the future of the quota scheme and of the arrangements for the provision of sheltered employment have yet to be taken.

The DRO service

6.11 The key figure in assisting with the resettlement of mentally ill people into employment is the Disablement Resettlement Officer (DRO). Through his knowledge of employment skills and local occupations and his experience and training in assessing working capacity, the DRO's function is to assist and advise staff at day centres, psychiatric hospitals and units on the readiness of patients to enter sheltered or open employment, to help them find it, and to advise on the appropriateness of employment rehabilitation and vocational training courses. He should arrange the next steps for admission to such courses and the selection of suitable job opportunities on their completion, including introductions to employers and preparations with existing employers for the return of former employees.

6.12 The number of experienced senior DROs is being doubled and the training given to new entrants has been lengthened and recast. Special attention is paid during training to the needs of the mentally ill. The experimental introduction of hospital-based DROs is dealt with more fully in paragraph 6.19.

Employment rehabilitation

6.13 Employment rehabilitation for people who have been mentally ill is available at employment rehabilitation centres run by the Employment Service Agency and at workshops run by other organisations. The aim of these centres is to help people to become as fit for employment as is possible within their physical and mental limitations and to assess the most suitable kind of employment for them. Such assessment would have particularly in mind the need to avoid undue stress and conditions likely to cause recurrence of mental illness. A research unit is to be set up by ESA shortly which will investigate the methods of rehabilitation used with a view to greater flexibility and variation of courses and facilities.

Vocational training

6.14 The Manpower Services Commission through the Training Services Agency provides a wide range of vocational training courses intended, in relation to the individual's capabilities, to develop existing or provide new skills for employment. For those who need it, training under residential conditions is provided by four colleges run by voluntary organisations with financial support from the Agency.

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Sheltered employment

6.15 Sheltered employment, organised either in special workshops or under defined arrangements with outside employers, has a well-established role in providing long-term employment for people who have a more or less permanent impairment of capacity. There are many mentally ill people with long-term limitations on their endurance, capacity for responsibility or powers of concentration, who can be usefully employed in this way. At present many of the mental hospitals are in effect providing sheltered work of a kind for the mentally ill, but with the diminution of the role of these hospitals and the expansion of residential facilities in the community for the mentally ill there is likely to be an increased need for sheltered workshop places for them. Discussions are continuing on the future role and organisation of sheltered employment in the light of the Department of Employment's consultative document on sheltered employment. One of the suggestions put forward in the document which is of particular relevance to people suffering from mental illness is that sheltered workshops should make more efforts to promote the long-term rehabilitation of their clients than has generally been the case in the past. The Government has not yet reached decisions on this; and the relationship of sheltered work to other services for the mentally ill will depend in part on the outcome of the current review.

Need for co-operation between services

6.16 The health, social and employment services obviously need to co-operate closely in assisting people who are or have been mentally ill. Hospital industrial and occupational therapy, local authority day centres, and employment rehabilitiation, vocational training, sheltered and ordinary employment should all be used flexibly so that the individual can draw on a range of services in which his progress can be attuned to his individual capabilities, psychological dependence and any residual effects of his illness. For those able to attain it, open employment will be the eventual goal, but it is important also that people should be able to move back into less demanding situations if the need arises.

6.17 The joint aim should be to open up as many avenues as possible for the employment of those who have been mentally ill. As well as making the best use of statutory and voluntary services, it will be important to elicit the co-operation of employers. Much can be done through informal contact to educate prospective employers so that job opportunities are not lost on account of unwarranted fears or misapprehensions about mental illness. Private employment agencies can also fulfil a useful role; and there are a few agencies which have developed specialised facilities for helping mentally ill or other disabled people.

6.18 The difficulties involved in rehabilitation for employment should not be underestimated. Mental illness may in any case result in a reduced ability to tolerate stress or to take responsibility and clearly work must not subject the individual to more stress than he can accept. On the other hand, successful return to outside employment requires acclimatisation to pressures of this kind and will not be achieved if the atmosphere is too protective. The staff in the different services need an awareness of the special difficulties of mentally ill people so that they can recognise problems when they arise and can adjust the

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pace and volume of the individual's work accordingly. In both open and sheltered employment, close links between the management and the psychiatric and social services are needed so that professional advice is readily available on individual and group problems.

6.19 As an illustration of how it may be possible to develop closer links between the various services, the Disablement Resettlement Service of the Employment Service Agency has made a number of experimental appointments of Disablement Resettlement Officers working full-time in some of the large hospitals. One of these experiments has been at a psychiatric hospital. It is hoped that the experiments will show that by having a representative of the ESA on the spot instead of visiting the hospital periodically, patients will be helped to commence suitable employment resettlement programmes at an earlier stage in their recovery, and will be referred at a more appropriate time than hitherto for help from the other agencies concerned. The initial signs are that the experiments have been reasonably successful.

6.20 The Employment Medical Advisory Service of the Health and Safety Executive is to study the medical aspects of employment rehabilitation for those who suffer from mental illness particularly where the working environment may have precipitated their condition; it is also investigating how stressful conditions may be identified and prevented.

6.21 The problems of resettlement into employment of mentally disabled people is one of the issues with which the National Advisory Council on the Employment of Disabled People will be particularly concerned over the next few years.

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CHAPTER 7

CHILDREN AND ADOLESCENTS

7.1 Recent accounts of the prevalence of emotional and psychiatric disturbance in young people, changes in society and developing patterns of treatment indicate the need for a reappraisal of how problems of disturbance may be tackled and how resources may be better used. The Department of Health proposes to issue a consultation paper which will seek to draw together the various threads of discussion on both child and adolescent psychiatric services. It will take account of the recommendations of the committee, under the chairmanship of Professor Court, which is looking at the whole field of child health services and which it is hoped will report early in 1976.

7.2 This chapter is concerned broadly with those up to age 19 although it is well recognised that there are some people over the age of 19 for whom adolescent services may be more appropriate than those provided for adults. No sharp dividing line can be drawn between childhood and adolescence; but it may be possible to distinguish different problems and different needs in adolescence from those applying in childhood.

Children

The nature of childhood disturbance

7.3 An understanding of childhood disturbance is still developing and the planning and organisation of child psychiatric services in the future has to be sensitive to this. Childhood psychiatric disturbance, except in a very few cases, does not present as a definable mental illness; moreover it has to be seen in the context of normal child development and the inter-action of factors both within the child and relating to the family, school and neighbourhood. The disturbance may show, for instance, as a disturbance in bodily functions, relationship difficulties, poor educational progress or difficult behaviour.

7.4 Family factors play a key role; sometimes these are themselves the result of poor environmental conditions but this is not always so. Further research is required into which family factors are most significant and how best to deal with them. Recent studies have already identified some: these include severe social disadvantage, family discord, poor child rearing practices, parental mental disturbance, parental criminality, one-parent families, large family size, unwanted pregnancy, and placement of the child in residential institutions.

7.5 Environmental factors may also have adverse effects. Examples are cramped and overcrowded housing conditions, lack of play and leisure facilities, and overcrowded schools.

7.6 Factors within the child include genetic and constitutional characteristics. Physical illness, brain damage, physical handicap or mental retardation may each produce an increased likelihood of psychiatric disorder. Altered susceptibility to stress and educational difficulties such as dyslexia have also to be taken into account.

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The needs of disturbed children

Prevention

7.7 Little is known about prevention of disturbance in childhood at present, but as factors which may increase the risk of disturbance are identified it is perhaps not unreasonable to hope that tackling these will help, especially because of their wider implications for the potential development and well-being of individuals and families. Progress with the very difficult problems of poverty, inadequate housing, and unemployment can probably only be considered as part of a long-term programme. On a shorter time-scale, more use of effective family planning methods might reduce other risk factors.

Early recognition and intervention

7.8 It is especially important that there should be early recognition and assessment of the need for help. A significant feature of recent years has been the recognition of disturbance in children under 5 years especially in vulnerable families. All those working with children have to be alert not only to signs of problems developing in the child but to the implications of distress apparent in other members of the family. The health visitor, through her routine visits to all households with children, and also the family doctor and local authority social worker are in a special position in this respect. All workers should know of the available services and be able to get access to them.

Treatment

7.9 The term treatment covers a wide variety of different approaches aimed at improving social functioning and developing individual potential to the full. Treatment approaches include individual and group psychotherapy, behaviour modification techniques, drugs, counselling and social intervention. Treatment may thus be carried out by a variety of specially trained professional workers and in a variety of settings. It is important for all workers to seek a common understanding of the underlying disturbance so that treatment measures may be planned in co-operation.

7.10 Treatment of the family as a whole or of relevant members of it is increasing and extended use of this method may affect the perception of the nature of child, parental and family disturbance and the training required by those working in this field. More knowledge of family and group dynamics is needed; and more opportunity for staff to develop skills and insight into these processes.

The role of the school

7.11 A child's school may be second only to his home in exerting powerful influences on his growth and development. Schools can help to tackle emotional disturbance at all three of the stages referred to above. First, a good school can help to promote sound development, emotional and social as well as intellectual. Secondly, children in school are under continual observation by teachers, who should be able to detect signs of disturbance and, where necessary, take steps to get specialist advice. Thirdly, schools can help to mitigate the effects of adverse outside influences on children and special schools and classes play an important part in the management and treatment of children with behavioural and emotional difficulties. To enable schools to be effective

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in all three roles, full support is essential from the network of school psychological, child health, child psychiatric and social work services, which in turn rely on the schools and classes to provide special educational treatment as part of their range of options. Increasingly the need is seen for staff from these services, as well as seeing individual children, to spend more time in schools talking with the teachers. Through close and imaginative co-operation between all the staff concerned, working with the parents, schools can do much to deal with childhood difficulties which may adversely affect mental health in adult life.

Organisation of services

7.12 In the Circular on Child Guidance issued jointly last year by the Department of Education and Science, the Department of Health and Social Security and the Welsh Office, child psychiatric services, together with the school psychological services, the social work services and child health services, were envisaged as together constituting a network of services for children in which, though each has its own independent organisation and functions, there are joint working arrangements for dealing with those children and their families whose problems call for a combined approach by more than one service.

7.13 A psychiatric service for children needs to enable the assessment, diagnosis and treatment of all children in the community—and of their families where relevant—who show evidence of mental illness or emotional disturbance. In addition to these basic functions it needs to provide consultation, advice and support for related services and for specialised establishments such as community homes. It also has an active part to play in the training of professionals in related disciplines.

7.14 Although hospital services are an essential element of a psychiatric service for children, and their continued expansion remains a high priority, the emphasis for the future needs to shift into the community—the home, the school, health centre or other community base. Staff in child psychiatry need to work much of their time away from hospital; in addition to providing clinical treatment, they need for example to provide advice to other children's services. Their training should prepare them for this wide role. It remains for the training bodies to develop and extend broad-based training at all levels. Recently devised training programmes for the further professional training of medical staff already include community experience.

7.15 We must aim not only to meet mental disturbance when it occurs, but to promote mental well-being, drawing as necessary on a wide range of services—child psychiatric services, paediatric services, services for adolescents and for the mentally ill generally, primary health care, local education services, social work services, the community home system, the courts, and voluntary agencies.

Research

7.16 More study and research is needed into the aetiology, incidence and nature of child psychiatric disorders, into effective methods of treatment and into different patterns of organisation.

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Adolescents

The nature of disturbance in adolescents

7.17 The age group involved is itself difficult to define. It is often taken as covering broadly ages 12–19 but neither can be regarded as hard-and-fast limits. The onset of puberty, which usually occurs by age 13, is commonly taken as marking entry into adolescence, but in some cases the nature of the disturbance may be such that an adolescent, so defined, is more appropriately treated with children. At the upper end of the age range the boundary is even more uncertain. Some 17 or 18 year olds may have adult values and behaviour patterns which make it quite inappropriate to regard them as adolescents. Others may, however, retain characteristically adolescent attitudes well into their twenties. These uncertainties make it extremely difficult to quantify the numbers involved; the use of the inclusive age range 12–19 (some 11·5 per cent of the population, a total of about 5·3 million) is only an approximation.

7.18 A second difficulty lies in the nature of adolescence itself. It is well recognised as a difficult period of development involving problems of adjustment, and of physical and emotional maturation, often leading to disturbed and disturbing behaviour and conflict with established institutions—home, school, and society. The difficulties are exacerbated by the pressures of adjusting to living in a modern intensively organised society, and to the changing patterns of behaviour of the age group itself and of adolescent values particular to each passing generation. An individual adolescent may moreover have personal problems in connection with his family, educational, religious or cultural situation. It must be emphasised that the great majority of adolescents do not require specific psychiatric help to cope with their problems; most do not come into contact with any psychiatric services now and do not need to do so. But at the same time disturbance in adolescence may in some cases be the beginning of a serious mental illness; and it is important that such cases should be detected.

7.19 A third factor is that within the adolescent age range may be encompassed an unusually wide variety of life styles. Most of those of school age live at home, although a significant minority are in boarding schools, and smaller numbers are in community homes or residential special schools and a still smaller group are in hospital. It is commonly believed that a small but increasing number under 16 have simply left home. Of those 16 and over a substantial minority will have left home to live in lodgings, hostels, or halls of residence, and some will live in self-supporting groups in rented flats or houses. As with younger adolescents some are in community homes or hospital, and some also are in borstals, detention centres or prisons. Finally, a phenomenon that has grown in recent years has been that of young people who do not live in any of the more conventional settings, but instead live in communes or are squatters, sleep rough or are homeless. This may result from a conscious decision—perhaps based on social or religious beliefs—or because the individual has drifted or been forced into such a way of life through inability to adapt successfully to more conventional modes of living.

7.20 Disturbance in adolescence presents difficulties in definition, in that diagnostic categories of mental illness as defined in adults apply only to a small proportion of cases. Disorder must be seen, as in childhood, in relation to

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the interaction between individual and environmental factors. The maturation and development that takes place in adolescence makes it difficult to differentiate behaviour directly related to a psychiatric condition from that which relates to a transitory or impaired phase of development and which may involve a crisis in identity or in personal relationships. Thus the presenting problems are a complex of interlocking psychological and social symptoms. These may show themselves as difficulty in adapting in the family, at school, or at work; loss of self-confidence; anxiety or depression; difficulties in inter-personal relationships with individuals; anti-social or delinquent behaviour; aggression; deviant sexual behaviour; drug-taking or heavy drinking; attempted suicide and suicide; and are often as inwardly disturbing to the individual concerned as to those around him. Adolescents who do require psychiatric treatment are thus thought to need a particularly broadly based approach, often involving the family and other agencies, and aimed largely at improving social functioning.

Need for psychiatric help

7.21 There are also particular difficulties in recognising the adolescent who needs psychiatric help in a sense that is not true of children and adults. For children, recognition of need may occur through the family, the primary health care team or, particularly with the expansion of the school psychological service. through the school. For adults it may come about through evident social malfunctioning. For the adolescent, however, particularly the older adolescent, these contacts may have been lost; and while social malfunctioning may be an indicator of need, it will often be disguised by patterns of behaviour that would be abnormal among adults but are not uncommon among young people. Conversely, the risk of exaggerating the need for psychiatric help is very real. The common assumption that because an adolescent is behaving in an anti-social way the answer is recourse to a psychiatrist is not founded on results or on a realistic view of the psychiatric manpower likely to be available. In practice some problems of adolescence may require little more than a better understanding from adults of this phase of human development; and when specialist help is required it may not be clinical psychiatric help specifically but a multi-disciplinary approach based on psychiatric understanding with contributions from a variety of professional workers.

7.22 Disturbance in adolescents is thus seen as encompassing social, educational, vocational and medical factors; a number of different agencies, of which psychiatric services are only one, need to be involved. For example, some special schools, the youth service and further education have an important contribution to make in providing opportunities for disturbed adolescents to continue their education and in re-establishing them in the community.

7.23 Even when an adolescent has been identified as requiring psychiatric help he may refuse or reject it. This may be because he associates it with values or institutions of the adult world which he suspects or rejects. Others may find it difficult to see the need for help because of a lack of reality in their own outlook or in their relationships with others. Many other adolescents are afraid of being classified as abnormal or as sick. Some may consider that it is society or the world about them that needs to change.

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Organisation and planning of services

7.24 The ways in which psychiatric services for adolescents have developed in the past have differed greatly. What seems to be needed for the future is that services should be organised so as to meet the special needs of adolescence. This means that for each facility, whether already in existence or in planning, consideration needs to be given to the way in which it relates to other facilities for adolescents in the area, and to the levels and type of staffing and training for them that are required. There is a particular need for health authorities together with local authorities to agree on the level of psychiatric support that they can give to the many agencies requiring it: community homes, the special education service, school psychological services, school and student counselling services, Social Work Services, the Primary Health Care Teams, the Youth Service, the Courts, the Probation Service and voluntary services. The psychiatric services also need to assist in developing insight into the nature of adolescent disturbance. As children and adolescents spend so much time in school and in further education, links with the education services are also important.

Provision of facilities

7.25 However, before real progress can be made towards providing comprehensive psychiatric services for adolescents it will be necessary to fill a number of well-recognised gaps in some of the basic requirements. In the clinical field although there has been marked progress in the last decade in the provision of in-patient places for adolescents, they are still only about a half of the number which has been estimated to be required, and there are some Health Regions which have no such facilities at all. Moreover some existing in-patient units have not yet developed a wide enough range of facilities to meet the varied needs of all groups of adolescent patients, with the result that such provision as there is cannot always be fully used. In the social services field, the number of day places and hostel places is still meagre and a significant proportion of the relatively small number of hostel places occupied by adolescents is provided by voluntary bodies, generally catering only for certain selected groups. In the community homes system, further provision is needed for difficult adolescents, some of whom are disturbed and may need psychiatric oversight, or, in a relatively small number of cases, treatment.

7.26 Various forms of walk-in advisory clinic have developed in this country and in other countries in Europe, and have demonstrated that, if appropriately presented, such informal facilities have a real part to play. They need to be closely related to other counselling services, particularly those which spring from what are outwardly applications for practical help, such as advice about accommodation, birth control, suspected pregnancy, work problems, drugs or drinking. Often requests for help over a problem related to the family may be a danger signal. To work effectively this entails a ready availability of psychiatric help; and such developments will be heavily dependent on the manpower that can be made available.

Staffing

7.27 At present only a limited number of psychiatrists have specialised in work with adolescents, and the scope for an increase is restricted by lack of specialised training. It is for the profession itself to decide what training is

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required in this field and in particular whether there should be a separate specialty of adolescent psychiatry. The Government is aware that this question is presently under discussion within the Royal College of Psychiatrists.

7.28 Psychiatric nurses engaged in treating adolescents have to be carefully selected and appropriately trained. Their numbers will also need to be increased; and in this respect the recent production by the Joint Board of Clinical Nursing Studies of outline curricula for training for nurses in the field of adolescent psychiatry is welcomed and it is hoped that this will give an impetus to the establishment of courses in this field.

7.29 The residential staff responsible for looking after disturbed adolescents in community homes often face intense pressure in the ordinary course of their work, and support and opportunities for further training are essential.

7.30 The training needs of these groups cannot be looked at in isolation and ways will need to be developed in which the experience gained in different services can be made more widely available.

Presentation of services

7.31 Services will need to be presented and publicised in such a way as to combat the very real problems of recognition of need and reluctance to accept help, to which attention is drawn above.

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CHAPTER 8

ALCOHOL AND DRUG DEPENDENCE AND MISUSE

8.1 Dependence is a complex medico-social problem though not of itself a mental illness or strictly a mental disorder. Psychiatrists, however, have taken the lead not only in treating the psychiatric and personality problems often found to accompany dependence, but also in exploring approaches to the treatment of the dependence itself.

8.2 Alcoholism and drug abuse present problems which run wider than, and differ in several important respects from, those presented by mental illness. The scope for prevention is broader. One may attempt to influence the availability of, and the attitudes of society to, the " agent ", be it drugs or alcohol, as well as tackling the problems of the individual and the stresses placed upon him by his environment. Physical medicine and the general hospital services have a part to play in the treatment of physical complications—liver disease, overdoses, withdrawal symptoms, malnutrition. Lastly, the development of services both for alcoholics and addicts is at a far more rudimentary stage than that of the psychiatric services generally. Most services are in some sense experimental. The special treatment units needed to explore new approaches and provide a focus for training staff in the problems of alcohol dependence are still being built up. Community services are provided to a far greater extent than for the mentally ill by voluntary effort.

Alcoholism

8.3 Alcoholism is recognised as a growing problem. It is a disease with both physical and psychiatric aspects and a major social problem with wide ranging effects on families and society at large, as well as on the alcoholic himself. It is thus the concern of an exceptionally wide range of professional workers: general practitioners, general physicians, psychiatrists, nurses, health visitors, clinical psychologists and social workers, probation officers, the police and those in the prison service. It seems to be generally accepted that the treatment of alcohol dependence itself, and of its psychiatric concomitants, is most effective with a multi-disciplinary approach, the lead, particularly in a hospital setting, usually being taken by the psychiatrist.

8.4 It is one of the characteristics of alcoholism that relapse is frequent: substantial changes may need to be made in the whole way of life of the alcoholic who must himself make a sustained effort to control his desire to drink. Treatment alone, unless followed up over what may be a long period by support of some kind may have little lasting effect. Alcoholism is pre-eminently a condition where a comprehensive medical and social approach, with an emphasis on continued care by a multi-disciplinary team serving a locality, is particularly appropriate. Services have still a very long way to move to achieve this objective and there are still many questions to be answered.

Prevalence

8.5 Different surveys indicate that about 400,000 persons in England and Wales (about 11 in every 1,000 of the adult population) have a serious drink

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problem. Most are male. Estimates vary of the number who have reached a late stage of alcoholism and of the number whose alcoholism has given rise to physical or psychiatric complications. Substantial local differences occur in the prevalence of alcoholism, but a fairly conservative estimate suggests that in a health district with a population of 250,000 there might be 2,000 persons with a serious drinking problem. Not all of these, of course, would accept or benefit from treatment at any particular point in time.

8.6 There is some evidence linking the prevalence of alcoholism positively with the total consumption of alcohol in a population. Total consumption can in turn be related to the cost of alcohol. This may be a particularly significant relationship as the price of some alcohol drinks has decreased in relation to the price of other goods in recent years; the same years have seen a very sharp increase in the total consumption.

Prevention

8.7 Problem drinking and alcoholism are increasing particularly among young people and women. Much more effort needs to be put into finding effective preventive measures. " Primary " health education in the sense of disseminating information about the effects of alcohol and creating sensible attitudes to its use is a far-reaching task but could, in due course, help to reduce the prevalence of problem drinking. The effectiveness of the normal health education techniques in relation to drinking habits is, however, largely untested and it is inevitably an uphill task in a society where there are considerable environmental pressures on people to drink. " Secondary " health education, directed towards encouraging those whose drinking has become a problem to seek help is perhaps more likely to show results in the short term, and some pilot work has already been undertaken by the Health Education Council. Other ways of identifying problem drinkers and alcoholics at an earlier stage may be possible, for example in the context of enforcement of drink and driving legislation, or through industry.

Treatment and rehabilitation

8.8 The general practitioner can play a most important role in early diagnosis. If a problem drinker is identified at an early stage there is often a good chance of his recovery, although even at a late stage treatment may be able to help him control his drinking. Knowledge about local facilities for the treatment and support of alcoholics and their families needs to be widely dispersed among the members of primary health care teams, social workers, personnel officers in industry and others whose role may lead alcoholics or members of their families to turn to them for advice. It is important too for hospital staff to recognise drinking problems among those in-patients or out-patients being treated for a physical condition or injury which could be associated with excessive drinking. The majority of identified alcoholics who are admitted to hospital for psychiatric treatment are treated in the general psychiatric wards of mental illness hospitals or in psychiatric departments in general hospitals. A minority—estimated at 35 per cent—are admitted to special units. In the main these special units treat their patients for their dependence on alcohol rather than for psychiatric illness. Treatment takes the form of group and individual therapy, drugs, aversion therapy or a combination of these, and the units tend not to accept patients with severe psychiatric

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and practical training as a postgraduate will help general practitioners in their role in the wider alcoholism treatment services. Other professions too, through their different training bodies, will have to consider the training implications of a more locally based service. The Joint Board of Clinical Nursing Studies has recently introduced a nine months' course for trained nurses, covering drug dependence as well as alcoholism. Experience in the Alcohol Education Centre and in providing in-service training in many of the alcoholism treatment units has shown that a multi-professional approach can also be valuable.

8.14 The recent reorganisation of the NHS provides an opportunity to examine alternative ways in which services could be provided. It seems sensible that under the new structure the Area Health Authority should be the focal point, both for collecting information about local alcoholism problems and for determining a strategy appropriate to the area, while in each district every effort should be made to establish an effective service for the locality. Resources further afield may need to be used where there are special needs, such as residential care for which there is no substantial demand locally. The machinery of the Joint Consultative Committee has a crucial part to play in ensuring the necessary collaborative approach among all the local services involved with alcoholics and their families. It seems clear that voluntary services have a part to play for many years to come: Area Health Authorities, as well as local authorities, separately or jointly, need to accept a degree of responsibility for their financial viability, and for the support their staff may sometimes need.

8.15 The emphasis in provision should perhaps turn towards a more locally based treatment service with much of the work done in the community or in an out-patient or day hospital setting, supplemented by in-patient facilities, whether these are specialised or part of the local psychiatric service. A problem for the long term is that the specialised units are at present sited in mental illness hospitals and as more locally based psychiatric services are developed, it will be necessary to think again about their role and location. The precise pattern of service adopted could vary from district to district, depending on local circumstances and need. Different ways need to be found of increasing the effectiveness and skill with which primary health care teams, social workers and others, deal with the drinking problems they encounter among their patients or clients. An early objective would be to build up in a series of chosen areas a balanced complex of preventive treatment and rehabilitation services which would provide an opportunity to evaluate experimental patterns and new ideas. There is a special need, too, to develop more effective services for those homeless alcoholics whose needs were studied in the Home Office report on the habitual drunken offender. These services—be they residential or day services—need to work closely with the treatment services as well as with the probation service, police and courts, and may also be able to co-operate with the staff of projects concerned primarily with accommodation for the homeless in reaching out to men who are not yet ready to accept that they have a drinking problem and need help.

8.16 At this time, when ideas are changing about the way in which treatment in community services should develop and questions of prevention are acquiring greater urgency, there is need for a recognised source of advice on alcoholism and services for alcoholics and problem drinkers. An Advisory Committee

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on Alcoholism has therefore been appointed. Initially its members will serve for 3 years, and during this experimental period it is hoped that they will be able to review and advise on many of the questions canvassed in this Chapter. They will also be responsible—and this is also an organisational experiment—for promoting the development of those services specially needed by homeless alcoholics—a field where progress has been slow. A special sub-group of the Committee has been set up to undertake this task, and other sub-groups will explore the scope for prevention, professional education, and patterns of treatment and community services in different parts of the country.

8.17 There is no reason why action should wait until this new Committee has reported. Much can be done during the next few years along the general lines indicated in these paragraphs, and without any additional call on health service or local government resources. Some of the changes may involve redeployment rather than additions to existing services or manpower. Experimental developments will continue for the present to be centrally financed in whole or in part. New patterns of provision may emerge and we should not yet draw up a definitive policy for future services.

Drug addiction and misuse

Background

8.18 The prevention of drug misuse and the treatment and rehabilitation of drug addicts calls for close co-operation between health, education, social services and law enforcement authorities and the voluntary bodies working in this field. Many of those addicted to or misusing drugs are young people with a variety of problems and often a history of emotional deprivation, disturbance and separation in the family, and sometimes institutionalisation; they may or may not see their drug misuse as a problem. Both licitly and illicitly obtained drugs are misused in a wide variety of ways. A contributory factor to certain types of misuse is the ready availability of certain drugs either from illicit sources such as break-ins at pharmacies or, especially in the case of barbiturates and other sedatives or hypnotics, through prescription.

8.19 Many addicts misuse several drugs depending on availability and fashion. The total number of misusers of drugs for which notification is not mandatory is difficult to estimate. Multiple drug misuse among young people appears to be increasing and the use of barbiturates gives cause for concern. The current number of active narcotic addicts is probably around 2,000 and the trend, though not steep, is upwards. The number of narcotic addicts in England known to the Home Office to be receiving drugs was:

31 December 1971	...	1,448	including some addicts whose addiction is mainly of therapeutic origin.
31 December 1972	...	1,493	
31 December 1973	...	1,723	
31 December 1974	...	1,885	

There is a small illicit market in heroin and methadone and most of those notified have a history of drug taking over a two- or three-year period. The total number of narcotic addicts is therefore likely to be greater than the number notified at any time. A pool of addicts on long-term maintenance who are unwilling to try to break their dependence on drugs has built up in the years since the present treatment system was introduced in 1968. At the

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end of 1974 39 per cent of notified addicts were under 25 and 74 per cent under 30: each year there have been fewer notifications of addicts in their teens.

Prevention

8.20 Drug misuse needs to be seen as part of the wider problem of society's over-reliance on drink, cigarettes, and prescribed drugs, such as sleeping pills or tranquillisers. It differs, however, in that most forms of misuse are illegal. Besides law enforcement prevention can be attempted in a variety of ways, including health education directed towards the public's attitude to drug taking in general and health education in schools where it can best form part of a discussion programme on health issues and problems of personal relationships. Not enough is yet known about the types of health education most effective in this difficult area. An ill advised approach, by feeding interest in drugs in the wrong way may actually encourage experimentation. Very few become dependent compared with the number who may experiment with drugs, and those who deal with the young need more skill in recognising the possible signs of regular drug misuse. More important in the long run than health education may be the availability of the advisory and therapeutic services discussed in Chapter 7 to help young people in those personality needs or inadequacies which usually underlie a continued and regular interest in drugs. There is room, too, for indirect forms of prevention, aimed at creating a range of enjoyable and emotionally satisfying activities for young people and encouraging easier and stable relationships between adults, including parents, and young people.

8.21 The Advisory Council on the Misuse of Drugs, which advises the Home Secretary and the Ministers concerned with health and education on all the problems to which the misuse of drugs gives rise has recently recommended the setting up of a steering group of doctors to direct a campaign of education aimed at persuading doctors to reduce their prescribing of barbiturates. Members of the public would also be encouraged to rely less on psychotropic drugs in general, especially hypnotics. A voluntary approach of this kind proved successful, a few years ago, with amphetamines.

Treatment and rehabilitation

8.22 The treatment and rehabilitation of addicts is seen very much as a single process. Treatment is regarded primarily as a clinical responsibility: and the drug-dependent person is regarded as having a medical problem which is probably best treated by a consultant psychiatrist with a special interest in drug addiction.

8.23 Treatment for narcotic drug dependence is provided mostly in special treatment centres set up for this purpose: these clinics have the subsidiary purposes of providing a licit and controlled supply of narcotic drugs for those addicts whose doctors consider they need them, and of acting as a means of restricting the extent of the illicit and uncontrolled market in these drugs. Most doctors including general practitioners are not able to prescribe heroin or cocaine, and although they can prescribe methadone they are encouraged to send addicts to the drug treatment centres of psychiatric hospitals for treatment. There are 15 out-patient treatment centres in London and 21 in the provinces. Treatment may take the form of withdrawal from drugs, or

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" maintenance " therapy where the objective is to stabilise the addict and enable him to function normally in the community. The approach is usually multi-disciplinary and although most addicts are treated on an out-patient basis some need a period of in-patient treatment or rehabilitation in a residential unit. Addicts dependent on narcotic drugs are mainly concentrated in the London area where there is some recent evidence that the pressure on treatment facilities is growing: the situation is under review. There are still some areas in the Home Counties and provinces where there are drug problems but no special treatment services available. The psychiatric services need to be developed in these areas to provide a local service and to relieve pressure on the London services.

8.24 Most non-narcotic misusers who find their way to the treatment services are treated through the general psychiatric services, either as out-patients or in-patients, alongside patients who have other problems. A few of the special treatment centres hold clinic sessions for the out-patient treatment of this group. Out-patient treatment, however it is provided, meets with the problem that many drug misusers fail to keep appointments or to persist with treatment. It may be that out-patient treatment is not seen by soft drugs misusers as offering them help with their real needs as they perceive them. An alternative approach might be for a multi-disciplinary team to work in a community rather than a hospital setting, offering a service to drug misusers as a part of the local services for young people described in Chapter 7. Older people with a drug misuse problem may be ready to accept treatment through the general psychiatric services. A particular problem is the drug misuser who is prone to take overdoses, sometimes, during periods of crisis, very frequently. Accident and emergency departments in some central areas are very familiar with this type of patient, who usually discharges himself as soon as he its resuscitated. There is a need to find some way of helping these very disturbed and self-destructive young people; and it is hoped, with the help of voluntary bodies working closely with certain accident and emergency departments, to offer a short-term residential unit where their needs could be assessed and an attempt made to persuade them to accept help.

8.25 The social work member of a treatment centre is an essential part of the multi-disciplinary team and acts as its link with other members of the social work services and with voluntary services. Many of those narcotic addicts who attend the treatment centres are leading reasonably stable lives, often living with their families and in employment, but each centre sees a number of disorganised addicts who need social work help with their emotional and family relationships, accommodation and education or employment. This group can be extremely difficult to help; the social worker needs to use his knowledge of young people and of drug dependent to develop skills in working with them and in interpreting their needs to others. At present it is exceptional for local authority social workers to be deeply involved with the problems of the multi-drug misuser who is not in touch with the treatment services, though there are signs that social workers who encounter a drugs problem in the course of their work are beginning to use the support of their colleagues in the treatment centres with their special experience and skills. It may be that this is the right pattern, and that, as suggested above, broad spectrum services for young people may best be able to help provided that they can call on the support of those with special experience of drug dependence.

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8.26 At present, few of the existing day or residential services for addicts and drug misusers are provided by local authorities, though most voluntary organisations working in this field rely heavily on local authority financial support. The voluntary services have so far developed in somewhat piecemeal fashion, though there is some movement towards co-ordination through the Standing Conference on Drug Abuse. Social services departments, aware of the changing needs in their own areas, may find that, as in London, they need to combine to set up or support the facilities needed by a whole region of the country. Local authority social workers and those in voluntary agencies, could well work more closely together.

Planning services

8.27 Drug dependence is a difficult area for information gathering. The parts of the picture have to be drawn together from many different sources—the local hospitals, the experience of family practitioners and chemists, schools, the police, and voluntary bodies. As with alcoholism, strategic planning and the co-ordination of activities in this field is a role in which Area Health Authorities, social services authorities, and the Joint Consultative Committees which link them, can play a vital part. Trends in drug misuse change, and it is important that there should be a flexible and local approach to the problem, so that a response can be made to needs as they arise.

8.28 As with alcoholism there seems a clear need for in-service training for professionals working in this field, and a multi-disciplinary approach, in encouraging the sharing of experience between those working with addicts in different settings, has much to recommend it.

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CHAPTER 9

MANPOWER REQUIREMENTS

Medical staff

General psychiatry

9.1 As new patterns of treatment and care develop the demands on the time of the psychiatrist will increase. Much of his time will necessarily have to continue to be devoted to in-patients and as the pattern of service changes he will have responsibility for patients in the psychiatric department at the general hospital, as well as in the related " division " of the mental illness hospital*; in some cases he will also have consultant oversight of the elderly severely mentally infirm. But there is a wide range of other calls on his time. There has been a marked increase in the number of out-patient sessions, and a striking increase in the number of day patients. These trends are expected to continue as more facilities become available and such services become more accessible. Also increasing are domiciliary consultations, enabling the consultant to assess the needs of the patient against his home background. Such domiciliary consultations, perhaps as part of a crisis intervention service, can sometimes be of valuable help in enabling the patient to overcome his problems without disrupting his home; but they may necessitate intensive visiting over the crisis period, and can make considerable demands on the time of medical and other staff.

9.2 In addition to his clinical functions, the consultant psychiatrist needs to devote time to consultative and supportive work for the social services, especially in day centres and residential accommodation. He has to train and supervise junior medical staff. He has also, as multi-disciplinary therapeutic teams develop, to play an advisory and supportive role in relation to other members of the team, and co-ordinate their different approaches to patients and their problems. As leader of the therapeutic team he will also have a considerable administrative role.

9.3 There is, however, increasing interest in whether some functions at present carried out by psychiatrists might not be undertaken, at least in part, by other professions. For example, the psychiatric nurse has already been recognised as a full member of the therapeutic team. In some areas " nurse therapists " are undertaking highly responsible work, particularly in relation to the treatment of phobias. A Working Party has been considering the role of the psychologist in the health service and it may be that in future the therapeutic component of his role in relation to the mentally ill will be much greater than at present. There is also the possibility that with local and ready access to psychiatric advice and to help from psychologists, social workers and nurses, more work with the mentally ill could be carried out by the primary care team.

Targets

9.4 Nevertheless even allowing for changes which may result from these developments, it remains clear that more consultants will be needed in future; and it is intended to increase the number of consultant posts in mental illness

*See Appendix, paragraph 3.

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to the extent that available resources permit. The first step towards formulating a series of target levels for medical staffing was taken in the context of guidance on mimimum standards for hospitals for the mentally ill issued in 1972. Authorities were asked to ensure that by the end of 1974 each hospital for the mentally ill had a level of medical staffing of at least one consultant per 220 resident patients. The aim was to bring the worst staffed hospitals up to at least a minimum level. At the last count in September 1974, this level had still not been reached in 22 hospitals. As the new pattern of services develops, with its increased emphasis on day patient and out-patient care, and advice and support to other services, the level of medical staffing needs to be related to the population served rather than to the number of in-patients. The present national average is one consultant to about 60,000 population, but this conceals wide variations in different parts of the country; and as a first target Health Authorities have been asked, as resources permit, to ensure that in each health district there is at least one consultant to 60,000 population. Again this is not seen as an optimum standard. The intention is rather to ensure that the benefits of consultant expansion are felt first in those districts which are most under-staffed. When the ratio of one consultant to 60,000 population has been reached the next objective will be to lower this ratio, as available resources of doctors and money permit, and ultimately to reach a ratio of one consultant per 40,000 population in all districts. These targets cover all work with adults: *i.e.* they include consultants working in the field of forensic psychiatry and those with the special interests referred to in the next paragraph.

9.5 Some psychiatrists take a special interest in particular groups of patients. An increasing number of new posts for example are for psychiatrists with a special interest in the elderly. Some patients may require intensive psychotherapy and there is a call for psychiatrists having special training in this field. Other psychiatrists have a special interest in addiction problems and it is likely that more posts of this sort will be required. At present none of these special interests are formal psychiatric specialties.

Forensic psychiatry

9.6 Forensic psychiatry is, however, a recognised psychiatric specialty, though apart from the special hospitals and the Institute of Psychiatry and its associated hospitals, there are at present only 10 consultant posts in the NHS. These are joint appointments between the Home Office and regional health authorities. The 8 senior registrar posts which have been established provide some scope for consultant expansion but a broader training base is needed. The introduction of regional security units in the next few years will no doubt call for a sizeable increase in numbers. It is understood that the Royal College of Psychiatrists is considering producing criteria against which individual training posts can be looked at.

Child psychiatry

9.7 Child psychiatry is recognised as a separate psychiatric specialty. At present the national average ratio of consultant child psychiatrists to total population is one to about 250,000, but here again, numbers are far below those needed to meet demands. As an initial target, it is hoped to bring the ratio up to one consultant child psychiatrist per 50,000 children, which is roughly equivalent to one to 200,000 total population. There is a wide variation in

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the level of staffing in different parts of the country and the intention is to concentrate first on those areas which are worst staffed. The number of consultant child psychiatrists needed in the longer term, and ways of increasing the number available, will be examined further in the consultation paper to be issued on child and adolescent psychiatric services and referred to in Chapter 7.

Adolescent psychiatry

9.8 Adolescent psychiatry is another area in which there is a serious shortage of specialist staff. The profession is at present debating what training requirements are appropriate and whether there should be a recognised specialty of adolescent psychiatry; and it would not be appropriate at this stage to formulate specific targets. The manpower requirements will also be considered in the consultation paper.

Training

9.9 Reference has already been made to the need for better training of medical staff. The direct object is better preparation of staff for their demanding role, but a valuable spin-off is the aid to recruitment which comes from providing stimulating postgraduate medical education. Young doctors are attracted to specialties with lively training. This is a matter primarily for the Royal College of Psychiatrists. A Joint Committee of the Royal College of Psychiatrists and The Association of University Teachers of Psychiatry has begun to accredit hospitals for training purposes, with the aim of ensuring that all training policies conform to acceptable standards.

The Joint Committee has also recently published its first report giving guidance on training programmes in psychiatry. The recommendations of the report " Psychiatrists in Training "* call for more teaching staff and more rotational training posts between teaching and non-teaching hospitals, to provide a good cross-section of experience. The Government stands ready to play its part with the College in evolving a coherent training and manpower strategy for the specialty.

9.10 Recent years have seen a welcome growth in academic departments of psychiatry with a consequent increase in the teaching of psychiatry at undergraduate and postgraduate level. This development has helped to improve the standard of psychiatric training at all levels.

9.11 There is considerable scope for improving both the identification and treatment of mental illness by general practitioners, and their skill in recognising when specialist treatment is needed. General practitioners already practising, as well as newly qualifying graduates, will need training for this role. The arrangement whereby some consultant psychiatrists have regular sessions in health centres and general practitioner group practices may itself lead to increased awareness. The Royal College of General Practitioners recognises the need for vocational training for general practice to include a psychiatric element in training programmes. The setting up of local psychiatric services will greatly facilitate this. The importance of psychiatry in undergraduate medical education was stressed by the Royal Commission on Medical Education. It emphasises the need for all undergraduate teaching hospitals to develop as quickly as possible a local psychiatric service integrated with related services in the community.

*Brook, Peter (1973) British Journal of Psychiatry Special Publication No. 7.

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Nursing staff

9.12 At 30 September 1974 there were in mental illness hospitals and units the whole-time equivalent of about 43,000 psychiatric nurses in post. This figure includes registered and enrolled nurses, student and pupil nurses and nursing assistants. The number of psychiatric nurses has increased in recent years, and the increase is expected to continue. Two important factors are the raising of the school leaving age and the Government's acceptance of the recommendations of the Briggs Committee on Nursing. The raising of the school leaving age has shortened the gap between the school leaving age and the minimum age of entry into nurse training, and is expected to bring in many of the school leavers who want to enter nursing but who would otherwise go into other careers because of the waiting period. The Briggs Committee have recommended that a period of psychiatric nursing should be included in all nurse training programmes and it is hoped that as more nurses see the scope and attraction of psychiatric nursing they will increasingly turn to this.

District psychiatric nursing service

9.13 Authorities were asked, in the guidance on minimum standards issued in 1972, to ensure by the end of 1974 a nurse staffing ratio of at least 1 nurse per 3 in-patients in all mental illness hospitals. At the last count in September 1974 this standard remained to be met in only 5 hospitals. But although we must continue to ensure an adequate level of nurse staffing in the mental illness hospitals, the planning of psychiatric nursing services for the future will need to relate nurse staffing to the total needs of the population rather than to one particular type of facility. The district psychiatric nursing service in the new pattern will be responsible for meeting all the psychiatric nursing needs of mentally ill people from the district—whether as in-patients, out-patients or day patients, and whether in local general hospitals or in the " division " of the mental hospital serving the district. It will include community psychiatric nursing for patients living at home and specialist nursing advice to primary care teams. It will also include the psychiatric nursing of elderly severely mentally infirm patients—whether in the mental hospitals or in local hospitals. As the pattern of services changes, so it will be necessary to change the pattern of deployment of nursing staff within the district and it will be one of the responsibilities of local nursing management to decide how best to deploy staff between the different elements of the district service at any one point in time.

Targets

9.14 In the light of present and expected future numbers of psychiatric nurses, the Department of Health and Social Security is aiming at an initial target in each health district of a level of psychiatric nurse staffing of 85 nurses per 100,000 population, increasing gradually as resources permit to 100 nurses per 100,000 population. The present national average is something in excess of 90 nurses per 100,000 but they are not evenly distributed. There has not yet been enough experience of the working of the proposed pattern of services for the mentally ill and units for the elderly severely mentally infirm to issue more detailed guidance on nurse staffing levels at this stage. In addition nurses will be needed to staff the psychiatric services for children and adolescents, as well as other special units such as the regional security units.

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9.15 At present the proportion of qualified to unqualified nurses is some 55:45 and is thought to be too low. A provisional aim is to move towards a position in which, nationally, some 60 per cent of psychiatric nursing staff, excluding teaching and administrative staff, are qualified, and within this total of qualified staff, a proportion of registered to enrolled nurses of the order of 2:1. It will clearly take some time to achieve this balance.

9.16 Psychiatric nurse training is at present undertaken almost entirely in the mental illness hospitals, although in practice nurses are increasingly working in local services which have a very different pattern of treatment and care. While the form of nurse training is mainly the responsibility of the General Nursing Council, the Government recognises the need for training to take place in general and community hospitals as well as in the mental illness hospitals, and welcomes the introduction of rotational schemes whereby students and pupil nurses spend part of their training period in a mental illness hospital and part in a general hospital psychiatric unit.

Social services staff and their training

9.17 It is not possible to isolate and hence to quantify social work staffing needs for the mentally ill. The staff include field social workers, residential staff and staff employed in day centres. Most of them are concerned not only with the care of mentally ill people but with the promotion of mental health in a wider sense and it is difficult to quantify the amount of time spent exclusively with the mentally ill as such.

9.18 The body responsible for social services training is the Central Council for Education and Training in Social Work; and several recent developments in their thinking have special significance in relation to work with the mentally ill. The Council have adopted proposals for the integration of training for field social work with training for day and residential care, and for the development of a new type of national training in addition to that leading to the Certificate of Qualification in Social Work (which has, up to now, been largely confined to field social work). Both forms of training will in future cover the whole range of work in the social services.

9.19 The Council recognise that while elements of training common to all sectors of the social services are needed there must also be provision for specific training in the needs and problems of particular groups such as the mentally ill. The Council have adopted the recommendation of their Working Party on Training for Social Work with Handicapped People (a term which for this purpose includes the mentally ill) that in addition to general training on the problems shared by all handicapped people there is a requirement to develop further and advanced training courses on the needs of particular groups such as mentally ill people and those suffering from severe personality disorders.

9.20 It is important that in each local authority social services department there should be senior staff who have had further specialist training in the specific needs of the mentally ill and can bring this experience to bear, both in giving specialist help and advice to the social work area teams, and in participating in the planning and development of services for the mentally ill. Some of the social workers who are working in the health service have already had such further training and full use should be made of their special experience.

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Particular account will have to be taken of training for social workers assigned to statutory duties in relation to the Mental Health Act. These duties often involve making decisions in emergencies. As a minimum staff will need continuing inservice training to give them confidence and skill to handle emergency cases when compulsory admission to hospital may be necessary.

9.21 These proposals for training will make heavy demands on resources, both of the social services themselves and of the training system. This is a particular problem in the context of the present economic situation, as a result of which the Government has for the time being had to ask local authorities not to increase the level of their total manpower establishments. It is, therefore, all the more important that authorities should do their best to provide training for existing staff so that they can be used to their full potential. The Department of Health and Social Security is well aware of the difficulties formed by these conflicting pressures, and has formed a Working Party, drawn from the other central government departments involved, the local authorities' associations, the Central Council for Education and Training in Social Work, the Personal Social Services Council and the professional organisations, to consider the whole question of the future needs for trained manpower in the social services in the light of the resources available.

Psychologists

9.22 Clinical psychology is one of the newer health service professions and has undergone very rapid development in recent years. At one time the main concern of psychologists in the health services was with relatively routine forms of psychological measurement such as intelligence testing, providing in effect an ancillary service to psychiatrists and other medical staff. More recently psychologists have developed a very wide range of assessment techniques which can play an important part in the choice and evaluation of treatment. They have developed a number of new forms of treatment based on psychological principles, including various forms of behaviour therapy, which are of particular value in the treatment of the mentally handicapped and those suffering from phobic conditions. In addition to their developing therapeutic role, the work of clinical psychologists is characterised by its emphasis on a teaching approach and by the application of research techniques in assessing the effectiveness of treatment and rehabilitation programmes.

9.23 The number of clinical psychologists in post at 30 September 1974 was over 600*. Of these about 470* were based in mental illness hospitals and units, but in addition psychologists based elsewhere—for example in Departments of Psychology in general hospitals—probably devoted a significant amount of time to the mentally ill. There is no doubt that in principle the contribution of psychologists in this field justifies a substantial increase in their numbers. The role and organisation of the profession have recently been reviewed by a working party whose recommendations are expected shortly. In the light of these recommendations the Government will be considering how the development of psychology services in the whole range of health service specialties, including mental illness, can best be assisted as resources permit, and will be examining the manpower implications.

*Whole time equivalent.

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9.24 One aspect of this development may well be to reinforce the tendency already apparent for the profession to acquire a more independent status within the health services, with Departments of Psychology increasingly taking responsibility for managing their own services. But at the same time it is essential in fields such as mental illness that the psychologist should work as a full member of the therapeutic team and that his work should be fully discussed and agreed with the other members of the team. This should not, of course, inhibit contact between psychologists and the primary care team, or between psychologists and social services staff.

9.25 When emotional and behavioural difficulties arise in schools and when special education needs are assessed, the contribution of educational psychologists and of school psychological services is important. Their support for teachers and pupils in special schools for the maladjusted and for those working with emotionally disturbed children will also help in the general field of mental health. Co-operation between psychological services for children developed by the area health authority and between psychological services developed by the local education authority is essential to ensure that the contribution of each is used to the best advantage.

Psychotherapists

9.26 At present the National Health Service does not have sufficient staff to provide specialised psychotherapy for all patients who might be considered to benefit from this form of treatment. Because of the amount of time required, psychiatrists who have had special training in this field can provide services for only a limited number of patients, and even with the prospective increase in the number of psychiatrists, there is unlikely to be any substantial increase in the amount of specialised psychotherapy psychiatrists are able to offer. The Department of Health and Social Security accordingly has proposed that there should be a review of the long-term priorities for the development of psychotherapy within the National Health Service, having regard to other mental health priorities and the resources likely to be available. One of the matters which will no doubt be considered in this review is the scope for employment within the health service of suitably trained psychotherapists without medical qualifications. In the meantime it has to be acknowledged that some groups such as those suffering from severe forms of phobia may be particularly vulnerable to this staff shortage.

Occupational therapists

9.27 Involvement in creative and constructive work, and regular assessment of progress, is an important part of treatment and rehabilitation programmes. At 30 September 1974 there were 565* occupational therapists employed in mental illness hospitals and units, and 1,102* unqualified staff. The numbers of occupational therapy staff in such hospitals and units have been increasing in recent years and it is hoped that this trend will continue. It will be important to make the most efficient use of qualified staff by employing aides working under the supervision of qualified therapists and a training course for aides has been established by the British Association of Occupational Therapists.

*Whole time equivalent

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The use of volunteers and paid staff in fields such as art, music and drama, working under the guidance of occupational therapists or the specialist therapeutic team, is also to be encouraged.

Domestic staff

9.28 Returns for September 1974 show that 27 hospitals accounting for some 20,000 occupied mental illness beds had less than 2·75 hours of domestic staff time available per in-patient week*. The achievement of a reasonable level of domestic staffing in all mental illness hospitals as soon as practicable is essential to relieving nurses of basic cleaning duties so that their skills can be applied to the treatment and care of patients.

*The returns covered staff working in wards and corridors only.

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CHAPTER 10

RESEARCH AND EVALUATION

The importance of research

10.1 In recent years there has been extensive research in Britain and overseas into both the fundamental nature of mental illness and various aspects of the needs of mentally ill people. The Medical Research Council has given much attention to this field and the contribution of the Council and its various specialised units to knowledge about mental illness has been substantial. The Department of Health and Social Security has also supported a continuing programme of research on mental illness.

10.2 Research is vital to the further development of the Government's policies. The body of existing knowledge about the needs of the mentally ill is, of course, very substantial and the policies put forward in this White Paper reflect a large measure of agreement (as well as some inevitable disagreement) about them. We owe much of this knowledge to research already carried out. But equally the foregoing chapters have made clear that there are serious gaps in what is known. On many issues only a tentative view can yet be formed. The ideas underlying the new pattern of services are not in themselves novel, but the development of these services has so far been uneven and patchy, and there has been no real experience as yet of the way in which they all work together as a comprehensive whole. Systematic research and evaluation are essential to assess their effectiveness in helping the mentally ill and to ensure that shortcomings are identified and rectified.

10.3 Research concerned directly with the operation of services cannot be divorced from the more fundamental study of the nature of mental illness and its response to different treatment approaches. In the longer term our thinking about the kinds of service required is bound to be affected by new knowledge and scientific advance. The pattern of services proposed in this White Paper provides a broad flexible framework within which there is ample scope for change and development.

Management and research

10.4 The Government's concern in sponsoring research is to improve the quality of care and the effectiveness of treatment. The achievement of this aim requires a degree of strategic direction to ensure that sufficient priority is given to the key areas in which issues of policy must be settled. The organisation of research on these lines presents problems which are by no means confined to the field of mental health. There is now a general recognition that in many areas of Government-sponsored research insufficient attention has been given to planning and the formulation of objectives. Proposals for reorganising the management of research and development were set up by the previous Government in the White Paper " Framework for Government Research and Development " (Cmnd 5046) published in July 1972. These proposals are now being

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implemented and, within the Department of Health and Social Security, a new advisory machinery has been established under the direction of the Chief Scientist with responsibility for promoting a dialogue between the Department, Universities and other research establishments. At the same time a comprehensive review has started, and will be continuing, of the overall shape of the research programme sponsored by the Department in mental illness as in other fields, and of its relationship to the work of the Research Councils.

10.5 New machinery has also been established within the organisation of the Medical Research Council which provides for the collaboration of the Council and the Department of Health and Social Security in the constant review and support of bio-chemical research over the whole field. Under these arrangements the Department of Health and Social Security will fund biomedical research related to their objectives, the research being organised and managed by the Council within their wider programme. Both the Council and the Department recognise the importance of research in the field of mental health.

Priorities for research concerned with services

10.6 Some provisional views have already been formed about the priorities for research in the immediate future, and the Government has invited potential research contractors to pay particular attention to these areas. At the same time independent initiatives or new ideas coming from research workers in the field will continue to be encouraged; and the Department of Health and Social Security will continue to consider individual proposals for support.

10.7 One of the important gaps in present knowledge is a satisfactory measurement and classification of the disability caused by mental illness. Present studies suffer from the lack of common definition of the various degrees of disability. It is difficult at present to assess in any scientific way the overall impact of mental illness on people's lives, and in turn the extent and kind of services needed.

10.8 The other priority areas which have been identified are mainly concerned with particular types of service, or services needed by particular groups of people. Among these is the " new " long-stay group discussed in Chapter 4; and proposals for further study are being considered. Another priority area for research relates to mental infirmity associated with old age. It is important to identify the nature and degree of mental infirmity which is beyond the scope of residential care and warrants hospital provision. Further subjects for research are the implications for services of the increase in mental infirmity among the elderly as national longevity increases, ways of refining assessment procedures and studies into current and alternative patterns of care. Research is needed in relation to mentally ill people cared for at home by their relatives—in particular, the kind of support and advice which relatives ought to have available. Work is also needed to identify the number of offenders and other patients requiring treatment under conditions of security.

10.9 In relation to particular types of service, the most serious gaps in present knowledge concern residential and day care services in the community.

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There has already been some research on the extent of need for residential and day care services and this is reflected in the guideline planning figures in Chapter 4. The background against which these services have to function is, however, changing and as these services expand it is important that they should be systematically evaluated and different approaches, for example units of different size, alternative patterns of staffing, compared. The Sociological Research Branch of the Housing Development Directorate at the Department of the Environment, who are engaged on a long-term study of the housing needs of handicapped people, are extending their investigations to examine also the housing needs of people who have been discharged from psychiatric hospitals. This study is being undertaken under the joint sponsorship of the Department of Health and Social Security and the Department of the Environment.

10.10 It has been emphasised throughout this White Paper that the treatment and care of the mentally ill involves the members of a number of different professions working closely together. They are highly skilled and trained staff and the way in which they are deployed is an important factor in making effective use of resources. Study is needed of the success of different working arrangements in a variety of settings. A further but related need is for research on the success of different forms of treatment, for example specialist psychotherapy as against physical treatment.

Worcester development project

10.11 The Department of Health and Social Security has sponsored the Worcester development project to test and evaluate a local pattern of services of the kind envisaged in this White Paper. The project relates to the Worcester and Kidderminster Health Districts and entails the development of a local network of health and social services in each district, including general hospital psychiatric departments, day hospitals, community psychiatric services, and local authority residential, day care and social work support services. Services for the elderly severely mentally infirm are also to be provided, together with improved residential and day services for the elderly.

10.12 When all these services are functioning as a whole, they are expected to replace the services at present provided by Powick Hospital for patients newly arising. One of the aims of the project is to consider how the problems of transition from a service based on a large mental illness hospital can be identified and resolved. The project is a co-operative exercise between the Department of Health and Social Security, the West Midlands Regional Health Authority, the Hereford and Worcester Area Health Authority, and the Hereford and Worcester County Council.

10.13 Several of the building elements of the project are already under construction and it is hoped that a number of the main units will come into operation in 1977.

10.14 Evaluation of the newly developing services in Worcester and Kidderminster is an integral part of the project.

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Southampton project

10.15 Reference has already been made to an experiment in the care of " new " long-stay patients at Southampton. This is part of a major research project supported by the Department of Health and Social Security to compare the operation of a district service based on a district general hospital psychiatric unit with one based on a " division "* of a mental hospital.

*See Appendix, paragraph 3.

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CHAPTER 11

PROGRESS TOWARDS THE NEW SERVICE

The backlog of present deficiencies

11.1 The Government is well aware that the pattern of services described in the preceding chapters is a far cry from that which exists today. While there are many general hospital units already in being, probably only about a third are of adequate size or offer standards of facilities for both day and in-patients capable of providing the focus of a full district service. The development of local services for the long-term care of the elderly severely mentally infirm has barely started and the elderly mentally infirm are accommodated by individual local authorities in a variety of ways, some of which are less satisfactory than others. Despite the significant improvements which have taken place over the last few years a number of the mental hospitals are still considerably overcrowded; and although a good deal of upgrading has been carried out many of the buildings are increasingly unsuitable for the accommodation of their ageing in-patient population. Returns for 1974 show in general an improvement on 1973 but a number of hospitals are still below one or more of the minimum standards for staff and amenities set by the Department of Health and Social Security in 1972: standards which are themselves only tolerable minima.

11.2 Individual local authorities are developing a wider range of day and residential services for the mentally ill, but some still have no facilities at all; and nationally the total level of provision falls far short of the guideline figures. Moreover the general pressure on the social services is very heavy. Social workers in local authority social service departments often have to carry very heavy caseloads and find they are often able to do little more than cope with emergencies and crisis situations. In these situations the more specific statutory duties—for example under the Children and Young Persons Act—inevitably in practice take priority over longer term preventive and supportive work.

11.3 The Government recognises that services have also been severely affected, not only by restraints on the financial resources available, but also by fundamental organisational changes in the health and social services: by NHS and local government reorganisation; by the reorganisation of the social services following the Seebohm Report; by the transfer of hospital social workers to local authorities and by new additional legal responsibilities, such as those arising under the Chronically Sick and Disabled Persons Act.

11.4 Multi-professional teamwork, adequate assessment, consultation and arrangements for after-care, and social work support are as yet sadly all too often theoretical ideals which bear scant relation to the practical realities. Inevitably patients and their families do not always receive the standard of care and support they should.

11.5 The Government is, moreover, aware that both staff and patients and their families have felt that central authorities had not only failed to appreciate

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the pressures under which the services are operating but were actively encouraging a precipitate rundown of the mental hospitals as a matter of policy; and that closures would be implemented ruthlessly leaving little or nothing in their place. We welcome this opportunity to stress that our aim is not the closure or rundown of the mental illness hospitals as such; but rather to replace them with a local and better range of facilities. It will not normally be possible for a mental hospital to be closed until the full range of facilities described in Chapter 4 has been provided throughout its catchment area and has shown itself capable of providing for newly arising patients a comprehensive service independent of the mental hospital. Moreover, even then, it will not be possible to close the hospital until it is no longer required for the long stay patients admitted to its care before the local services came into operation.

Public sector costs of introducing the new service

11.6 The gulf between the existing service and the pattern of service advocated in the White Paper may be wide: but it is right that we should at least have a reasonably clear picture of the kind of service at which we are aiming even if it has to be accepted that progress in the next few years may be slow and that in some parts of the country in particular, it will be many years before this pattern of services can be realised in practice.

11.7 The new pattern will involve a radical change in the balance between hospital and community care inasmuch as it envisages a substantial decrease in in-patient services and a substantial increase in day hospital and out-patient treatment, and in day and residential care within the community. The implications for public sector costs have been the subject of an operational research study commissioned by the Department of Health and Social Security. An important conclusion is that the running costs, taking health and social services together, are estimated to be much the same whatever the pace of introducing the new pattern. National Health Service running costs are expected to rise very slightly over the first 10 years or so and then decline, offsetting the increase in social services running costs.

11.8 Two separate elements of capital investment are involved. One is investment on the new pattern of services. The other is the cost of upgrading the mental hospitals. Most of those that will have more than a short or medium term life will require expensive upgrading. The cost of upgrading is thus dependent on the pace of introducing the new pattern. The total national capital investment, taking account of existing services and the possibility of using adapted accommodation, would amount to an average of around £30 million* per annum on health services and £8 million* per annum on personal social services over a 20–30 year period.

Translating philosophy into action

The difficulties

11.9 It is as well to be frank about the difficulties. Financial resource constraints alone, quite apart from the physical and manpower constraints, mean that it will inevitably be a very long time before a broadly comprehensive modern service can be achieved in every district in the country; and there are bound to be new developments and ideas in a time dimension of this kind.

*At November 1974 prices.

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11.10 But there is perhaps an even more fundamental difficulty. In the last resort achievement will be dependent on the community's willingness to accept an increased responsibility for those of its members who are or have been mentally ill. Public attitudes have changed in recent years and are still changing; and may no doubt be reasonably expected to become more tolerant as the development of local services brings about a better realisation of what mental illness is and how those suffering from it can best be helped. Time is needed to prepare the way and to accustom the community to these added responsibilities. The very length of the time scale may help in this respect.

11.11 We must face the fact that the pattern we are advocating entails at least in part a transfer of responsibility to the social services and an increase in resources for this purpose. How this is to be done is a big and difficult issue; and the likely constraints on public expenditure, particularly in the next few years, are such that hard questions of priority have to be faced.

11.12 We cannot look at the resource requirements of the mentally ill in isolation, whatever priority they are accorded. We have to look at the totality of the financial and manpower resources likely to be available for the health and social services, and at the competing demands on these resources as a whole. There is moreover the conflict which sometimes arises between national and local priorities. In individual local situations the priorities may be very different from those seen at national level.

11.13 Yet another problem is the complexity of the planning involved. The plans drawn up by the health authorities and local authorities for services for the mentally ill in each area must be joint plans. The planning of psychiatric departments in general hospitals has to be part of the wider planning not only of the hospitals themselves but of health service developments in general. Discussion on which local services can be developed first are dependent on siting and other local practical considerations. The timing has to take account of the physical condition of the existing mental hospitals; and the extent to which upgrading will be needed in these hospitals if local replacement services are not provided at an early stage. Planning must also take account of the need for various regional and area services. For example, regional security units and special units for alcoholism, drug dependence and children.

Resource planning assumptions

11.14 A new system has been established within the Department of Health and Social Security for reviewing each year over the whole field of health and social services the prospective developments in each sector and their financial and manpower resource implications. These reviews are intended to help reach decisions on priorities over the following 10 years, and on objectives which are consistent with the best assumptions we can make about the total resources likely to be available over the period.

11.15 The first of these Departmental reviews is under way; and when completed should enable provisional guidelines on priorities and objectives to be drawn up for consultation with NHS and local authorities. So far as services for the mentally ill are concerned, the running costs, taking health and social services together, seem unlikely to vary significantly within any likely

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pace of introducing the new pattern of community care. Faced as we are with the prospect of very little room for development of the health and personal social services over the next three or four years except by making better use of existing resources, it would be unrealistic to expect any substantial increase, in this initial period, in the scale of capital investment. But on the assumption that there will be a modest growth in real terms in the amounts available for the health and personal social services after that, and bearing in mind that for services for the mentally ill only a very slight rise in running costs as a whole is entailed, it seems reasonable to assume that it may then be possible to provide for the necessary capital investment on the scale envisaged in paragraph 11.8.

Joint health and local authority planning

11.16 Joint planning of health and local authority services is essential for such services. The fact therefore that the planning system referred to in paragraph 11.14 above will provide national guidelines for health and local authority services which are based on realistic resource assumptions makes it particularly relevant. The national guidelines will need to be translated into individual regional and area guidelines (including resource assumptions); and it will be a high priority task for area health authorities and local authorities to produce joint plans for the development of services for the mentally ill on the basis of these assumptions. The medium for joint planning in each Area will be the Joint Consultative Committee which both authorities have been required by the NHS Reorganisation Act to establish for purposes such as this.

11.17 These joint plans will form part of the plans produced for the development of health and personal social services generally. For the National Health Service these will be of two kinds; strategic plans examining and setting out the realistic prospects of developing services in the next 10 years and annual plans detailing the action proposed to implement these strategies and priorities in the next 3 years. There will be a regular process of reviewing these plans and updating them in the light of progress achieved. They will need, among other things, to identity which mental illness hospitals are likely to have a relatively short life, which are likely to reduce their scale of services and which are likely to have a continuing major role beyond 10 years. It is proposed that a similar planning process should be followed for the personal social services; the results of joint planning of services for the mentally ill will thus be reflected consistently and in parallel in local authority as well as NHS plans. (Discussions about local authority planning on this basis will be pursued with the local authority associations.) The aim would be for the initial plans from both sets of authorities to be ready by the end of 1976 so that it would be possible to extract from them a national picture of planned development of services for the mentally ill and publish it in an appropriate form during 1977.

11.18 There will be many considerations to be borne in mind. Psychiatric units in general hospitals often have to form part of a wider development and there may well be little room for manoeuvre in the timing of their provision. Local authorities will need to understand this, and to plan to give particular priority to providing supporting social services in those parts of their areas where such units are coming into operation at an early date. Conversely, health authorities must appreciate that a general hospital psychiatric unit cannot function efficiently in isolation; it can only function properly as part of

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a whole network of local services, of which social services residential, day care and domiciliary support are essential elements. Lack of such services might mean, for example, that the day hospital facilities in the psychiatric unit cannot be fully used because patients have not got a sufficiently supportive home environment to return to at night, and as a result patients in the unit might have to remain as in-patients for longer periods than is necessary on medical and nursing grounds.

11.19 Another important factor is the timing of local provision of services for the elderly severely mentally infirm. These will need to be provided in parallel with, if not ahead of, the general hospital psychiatric unit. Failing this the staff at the mental hospital will be left to care for patients who make heavy demands on nursing staff, often in unsatisfactory physical conditions. If such a situation is allowed to arise it will inevitably be damaging to morale and staff recruitment.

Regional strategies

11.20 A further element of complexity is that the various area plans will often be interdependent and the development of regional strategies is essential. This is partly because some services overlap areas; partly because it will be necessary to consider what plans should be made for patients needing continuing care when numbers in a mental hospital are reduced to the point at which the hospital becomes no longer viable; and partly because some services, for example, regional security units, are regional in nature.

11.21 Throughout the whole planning process, health authorities will need to have particular regard to the implications for the related mental hospitals of the developments of local services in each district. This aspect of the planning and management of services is of fundamental importance, both to the successful introduction of new patterns of care and to the maintenance and improvement of standards at the mental hospitals themselves. Because of the importance attached to this, a separate Appendix has been included in which some of the problems of the transitional period are discussed in more detail.

Staff involvement

11.22 In formulating the joint area plans and in developing the regional strategies, the staff of the mental hospitals and those in the developing local services should be kept fully in the picture. Some of the more senior officers will, of course, have an opportunity to contribute to the planning, through the medium of health care planning teams and in groups servicing the Joint Consultative Committees, but it will be necessary to arrange meetings and seminars, so that all the staff representatives and, indeed, as many as possible of the staff themselves have a first hand opportunity to learn what is proposed and to ask questions. Area Joint Staff Consultative Committees, or their equivalents, and similar bodies at District, Sector or Unit as appropriate, will be the channel for formal consultation with staff representatives as a body. Staff will be particularly concerned with arrangements for transfer between the mental hospital "division" and the developing local district services, the protection of their various interests and with the timing of all proposed changes.

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APPENDIX

THE MENTAL HOSPITALS IN THE PERIOD OF TRANSITION TO THE NEW PATTERN OF SERVICE

1. Some mental hospitals will continue in use for many years. However, because the buildings may remain this does not mean that the pattern of service based on them need remain the same. One has only to consider the pattern of care for which the hospitals were originally designed and the kind of service which they now provide to appreciate the possibility of further far-reaching changes. Moreover, the policies set out in this White Paper go much wider than the provision of buildings; improvements in staffing levels and the introduction of new patterns of co-ordination and integration will also benefit those services which are based on mental hospitals. Indeed it is essential that they should: it is in the mental hospitals that most patients will in practice continue to receive specialist treatment for many years. Moreover so long as these hospitals form part of the district service, it is important that doctors and nurses should continue to receive part of their training in them. We must ensure that the organisation of the services of the mental hospitals is integrated with that of the newly developing local facilities, and that the staff in the mental hospitals participate in the planning and development of these new facilities.

2. Much has been written by the Hospital Advisory Service and by others about the dangers during the transitional period of creating a two-tier service with the general hospital unit providing a first class service limited to selected patients who respond most readily to treatment, and the mental hospital left as the place to which the less attractive types of patients can be passed on. A two-tier system does, sadly, already exist within a number of mental illness hospitals themselves, in the admission wards on the one hand and the long stay wards on the other. In each situation the service provided will ultimately depend partly on operational policies and the deployment of resources and partly on the attitude of individual members of staff to their work. The Government's concern is that the management and organisational arrangements should be such as to promote an integrated service.

3. With this in mind Health Authorities have been asked to split the mental illness hospitals which serve more than one district into organisational units referred to as " divisions " each representing that part of the hospital which serves a health district in the hospital's catchment area. Wherever possible, the wards making up a " division " should be in the same part of the hospital. Each division should have its own medical and nursing staff and be responsible for providing a service to its health district. On average such a " division " might have initially a total of some 400 or so beds and be served by 3 or 4 consultant-led teams. This organisational arrangement takes a step towards giving a local identity to the service and encouraging a sense of allegiance on the part of the staff of the " division " towards their health district.

4. Whether or not the " division " should be further sub-divided so that individual therapeutic teams are each responsible for their own geographical sectors of the district is something to be decided locally in the light of the characteristics of the individual district. (See also paragraph 3.13.)

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5. As the local district psychiatric facilities develop they should be integrated organisationally with the corresponding " division " at the mental hospital so that, for example, there is joint medical and nurse staffing of the " division " and the new district facilities. Some of the nurses who hitherto have provided a service to the district from the mental hospital " division " may be redeployed to help provide the district service from the general hospital unit or community hospital. In this way it is hoped that staff will increasingly think of their responsibilities in terms of a district service which, wherever it is provided, whether from a mental hospital " division ", a general hospital psychiatric unit, a community hospital, or in domiciliary and supportive work in the community itself, is all part of the same district service.

6. The District Management Team for each health district has responsibility for the formulation of policies for the development of services for its population. It will therefore be concerned not only with the provision and development of psychiatric services locally but also with the operational policies and standards of service of the relevant mental hospital " division ". This has particularly important implications for the deployment of nursing staff, and the aim must be to move towards a position in which each district has a divisional nursing officer responsible for the whole range of psychiatric nursing services so that needs can be properly represented at the appropriate level of decision taking.

7. In carrying out its work the District Management Team will usually have the advice of a Health Care Planning Team for mental illness services which includes members of the staff based at the mental hospital " division ", and members of the staff in the developing local services. It will have an important role in alerting the District Management Team to any imbalance of resources in different parts of the district service.

8. Community Health Councils are concerned with the provision of health services generally for their community. The statutory duties of a Community Health Council relate to services within its district but it is important that the Council should look at the provision of mental illness services as a whole for each district, including the services provided by a hospital " division " from outside the district. There will therefore need to be suitable arrangements between different Community Health Councils (and if necessary consultation with Area Health Authorities or their officers) to enable a Council to visit a hospital outside its own district and to comment to its own District Management Team on the services provided there for its district. The District Management Team will need to ensure that these comments are made known to those responsible for the management of the hospital as a whole.

9. It is important that the policies for the different " divisions " of a mental hospital should be co-ordinated. Such co-ordination is the responsibility of the Area Health Authority. The Authority is also responsible for the development of operational policies for services common to all " divisions " such as domestic and catering facilities. On the basis of the co-ordinated policies responsibility for the day-to-day management of the hospital as a whole will have been delegated to an Area Team of Officers or one of the District Management Teams.

10. Plans for the development of local district facilities will need to be viewed in the light of their implications for the related mental illness hospitals.

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Some mental hospitals (or " divisions " within them) will by virtue of their location in relation to their catchment population, and perhaps also their physical condition, be less able to make an effective contribution to a local district service than others; and authorities in drawing up the joint plans referred to in Chapter 11 (paragraphs 11.16–11.19) will need to concentrate initially on the replacement of those hospitals (or " divisions ") whose physical conditions and geographical location are likely to provide the greatest handicap. Within individual hospitals there may also be advantage from the point of view of the hospital as a whole in phasing the introduction of general hospital units in the various districts served by it, so that at least one " division " continues to provide an active admission service until the hospital is nearing the end of its life.

11. Where it is clear that hospitals or individual " divisions " are not among those selected for early replacement, the health authorities concerned must carry out a realistic assessment of the way the existing facilities can best be used. Such studies will need to be carried out in conjunction with local authority and primary care staff, the advice of the Health Care Planning Teams playing an important role in overcoming problems of location in relation to individual districts. It may, for example, be possible for health centre or local authority accommodation to be used as a base for community psychiatric nursing services: local authority social services departments may be able to play a more significant role in the management and staffing of those hospital wards which accommodate long-stay patients who would be living in the community were suitable facilities available for them. Alternatively there may on occasions be health service accommodation which can be made available to local authorities or voluntary organisations for use as a day centre or a residential unit for these patients. Not least an attempt should be made to develop links between psychiatric services and the general hospital services, if only by providing accommodation at the general hospital from which a psychiatric consultation service can be offered to other departments at the hospital.

12. Maintaining the physical structure and improving standards of decoration, toilet and other facilities at the mental illness hospitals is essential if morale of the staff is to be maintained and the burden of nursing an increasingly ageing in-patient population to be eased. An important by-product of a long-term strategy for services for the mentally ill is the development of an upgrading plan in which the scale and type of upgrading needed in each hospital is assessed in the light of the anticipated timing of development of replacement services in the districts it serves and the resultant effect on the number and types of patients likely to be resident in the mental hospital during the various phases of its life. This upgrading plan is needed to ensure that limited resources are spent at the right time and on those parts of the hospital which are expected to have the longest life.

13. If the transitional period is to be accepted by the mental hospitals as a challenge in the positive sense, they must be given an adequate share of manpower and other resources with which to meet it. The management arrangements outlined above will provide a framework within which those responsible for local management will have every opportunity to deploy resources flexibly

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between the old and new parts of the service. The Government will also be considering the need to give further guidance on minimum standards of staffing, food, clothing, space, personal amenities, etc., in the mental hospitals.

14. It should not be forgotten that it is the staff of the mental hospitals who have been the pioneers of the last quarter century: they may well prove to be the pioneers of the next, providing they are given the resources and opportunity to participate in new developments, particularly in experiments and research into better ways of providing care and treatment in the context of a local service. Some of the problems identified elsewhere in this Command Paper as requiring further research could well be studied in the mental hospitals. Indeed in a number of areas the mental hospitals will continue to be the focal point for certain aspects of research for many years to come. For example, the mental hospitals have in particular developed a wealth of valuable experience in caring for longer stay patients. They should be encouraged, in conjunction with local authority social services departments, to use this experience both to develop new approaches to the rehabilitation of existing and often institutionalised long-stay patients, and to experiment in alternative forms of hospital care for newly arising long-stay patients.

Printed in England for Her Majesty's Stationery Office by Oyez Press Limited
Dd 294719 K160 10/75

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